



NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 410

OREGON HEALTH AUTHORITY

HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED: 09/30/2026 1:23 PM

ARCHIVES DIVISION SECRETARY OF STATE

FILING CAPTION: Adopt the OHA Prioritized List of Health Services and Implement the Benefit Update Project

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 10/21/2026 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Filed By:

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HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 10/20/2026

TIME: 2:00 PM - 2:45 PM

OFFICER: Brenna Bird

REMOTE HEARING DETAILS

MEETING URL: [Click here to join the meeting](#)

PHONE NUMBER: 1-669-254-5252

CONFERENCE ID: 1657257263

SPECIAL INSTRUCTIONS:

Topic: Public Hearing Chapter 410 OHA Benefit Update Project

Time: Oct 20, 2026 02:00 PM Pacific Time (US and Canada)

Join ZoomGov Meeting

<https://www.zoomgov.com/j/1657257263?pwd=m8kW7iG96dWJiWKVbtCq08ftfNzrGG.1>

Meeting ID: 165 725 7263

Passcode: 344060

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NEED FOR THE RULE(S):

OHA's Section 1115 waiver authority to use the Prioritized List of Health Services (Prioritized List) in its current form expires on January 1, 2027. Specifically, the use of condition/treatment pairings relative to a funding line is no longer permitted as currently used. The current Prioritized List maintained by the Health Evidence Review Commission (HERC) is structured around a funding line and utilizes this mechanism to effectively scale the OHP Benefit Package, which will not be permitted beginning January 1, 2027, absent the waiver.

HERC's enabling statute dictates the cadence in which HERC may make updates to the Prioritized List, with the next statutorily permitted update being no earlier than 10/1/2027 (ORS 414.690(7) and (9)). As a result of this timing mismatch, OHA will use its statutory authority to adopt an "OHA Prioritized List" which will be substantively identical to what HERC has been developing for 1/1/2027 (see link below). The proposed rules indicate that OHA shall conduct further rulemaking to coincide with HERC's adoption of an updated Prioritized List effective January 1, 2028 to return to the use of HERC's Prioritized List.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

ORS 414.690 at https://www.oregonlegislature.gov/bills_laws/ors/ors414.html

HERC's draft 1/1/27 Prioritized List of Health Services at <https://www.oregon.gov/oha/HPA/DSI-HERC/PrioritizedList/1-1-2027%20Prioritized%20List%20of%20Health%20ServicesV2.0.pdf>

Oregon Health Plan Benefit Update Project website at <https://www.oregon.gov/oha/hsd/medicaid-policy/pages/benefit-update.aspx>

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE:

The Benefit Update Project will result in a small increase in the coverage of services that have historically appeared in the unfunded region of the Prioritized List. This impact on health services covered by the Oregon Health Plan is not anticipated to change racial equity in either a positive or negative manner in Oregon.

FISCAL AND ECONOMIC IMPACT:

OHA has conducted a BUP rate-setting analysis and will monitor the fiscal impacts going forward. OHA actuaries and Marsh evaluated BUP impacts as part of 2027 rate development, resulting in an increase in the statewide monthly CCO

capitation rate of \$3.77 per member per month for a total of \$51.7M for 2027 to cover the costs for new services, in addition to consideration within the development of CCO administrative cost loads. OHA will monitor changes in costs, utilization, hearings, appeals, and administrative activity during implementation and will consider documented impacts through applicable CCO rate development processes.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) RAC members representing CCOs indicate that they will experience an increase in administrative burden, particularly as coverage determinations will shift to a stronger dependence on medical necessity reviews. They also believe costs will increase due to infrastructure changes and that the utilization of prescription drugs as a result of these changes will be higher than what is projected.

(2)(a) Small physician practices and independent pharmacies that serve OHP members are examples of small businesses that could be impacted by the rule changes.

(b) The way providers request prior authorization of OHP services may increase administrative activities.

(c) It is unknown at this time how potential costs associated with any increase in administrative activities would be offset by additional revenue from an increase in covered benefits that they may provide.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Listening sessions were held with providers to gather feedback to inform the early stages of rule development.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

410-120-0000, 410-120-0025, 410-120-1160, 410-120-1200, 410-120-1210, 410-120-1560, 410-120-1570, 410-120-1600, 410-120-1990, 410-121-0040, 410-121-0147, 410-122-0080, 410-122-0090, 410-122-0202, 410-122-0250, 410-122-0300, 410-122-0560, 410-122-0630, 410-122-0658, 410-123-1060, 410-123-1160, 410-123-1260, 410-123-1620, 410-124-0000, 410-125-0045, 410-125-0080, 410-127-0040, 410-127-0060, 410-129-0020, 410-129-0200, 410-130-0000, 410-130-0160, 410-130-0190, 410-130-0200, 410-130-0220, 410-130-0240, 410-130-0255, 410-130-0368, 410-130-0670, 410-131-0040, 410-131-0080, 410-131-0120, 410-131-0160, 410-133-0040, 410-133-0060, 410-136-3000, 410-140-0010, 410-140-0140, 410-140-0410, 410-141-3820, 410-141-3825, 410-141-3830, 410-141-3835, 410-141-3855, 410-141-3885, 410-146-0000, 410-146-0080, 410-146-0085, 410-146-0220, 410-146-0470, 410-147-0000, 410-147-0020, 410-147-0120, 410-147-0260, 410-147-0500, 410-148-0000, 410-148-0020, 410-148-0260, 410-151-0001, 410-151-0002, 410-170-0080, 410-172-0770, 410-172-0850

AMEND: 410-120-0000

RULE SUMMARY: Remove reference to a funding line on the Prioritized List. Revise definition of "Prioritized List of Health Services," including addition of definition for "OHA Prioritized List." Add definition of "Letter of Medical Necessity."

CHANGES TO RULE:

410-120-0000

Acronyms and Definitions ¶

Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), chapter 410 administrative rules, applicable to medical assistance programs. This rule does not include an exhaustive list of program acronyms and definitions. For program and services definitions, see the appropriate OAR in the applicable division of chapter 410 administrative rules, and any appropriate governing acronyms and definitions in other Authority chapters such as 309 and 943 or the Oregon Department of Human Services (Department) administrative rules found in chapters 411, 413, or 461, or contact the Authority.¶¶

(1) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Authority or in reimbursement for services that are not medically necessary or medically appropriate. It also includes recipient practices that result in unnecessary cost to the Authority.¶¶

(2) "Action" means a termination, suspension of, or reduction in covered benefits, services, eligibility or an increase in beneficiary liability. This includes a determination by a skilled nursing facility or nursing facility to transfer or discharge a resident, or an adverse determination with regard to the preadmission screening and resident review requirements. For the definition as it is related to a Coordinated Care Organization (CCO) member, refer to OAR 410-141-3500.¶¶

(3) "Acupuncturist" means an individual licensed to practice acupuncture by the relevant state licensing board.¶¶

(4) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law.¶¶

(5) "Acute" means a condition, diagnosis, or illness with a sudden onset and that is of short duration.¶¶

(6) "Acquisition Cost" means, unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply, or equipment plus any shipping or postage for the item.¶¶

(7) "Addictions and Mental Health Division" means the Division within the Authority's Health Systems Division that administers mental health and addiction programs and services.¶¶

(8) "Adequate Record Keeping" means documentation that supports the level of service billed. See OAR 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.¶¶

(9) "Administrative Medical Examinations and Reports" means examinations, evaluations, and reports, including copies of medical records requested on the Oregon Health Plan (OHP) 729 form through the local Department branch office or requested or approved by the Authority to establish client eligibility for a medical assistance program or for casework planning.¶¶

(10) "Adults and Youths Discharged from an HRSN Eligible Behavioral Health Facility" means Members who have been discharged from one of the settings listed below within the last 365 calendar days. Eligibility for HRSN Services shall expire on the 366th calendar day after discharge.¶¶

(a) Acute Care Psychiatric Hospitals as defined in OAR 309-015-0005,¶¶

(b) Institution for Mental Diseases as defined in 42 CFR 435.1010,¶¶

(c) Integrated Psychiatric Residential Treatment Facilities and Residential Substance Use Disorders Treatment Programs as defined in OAR 309-022-0105,¶¶

(d) Residential Treatment Facilities (RTF) as defined in OAR 309-035-0105,¶¶

(e) Residential Treatment Homes (RTH) as defined in OAR 309-035-0105,¶¶

(f) Secure Residential Treatment Facilities (SRTF), as defined in OAR 309-035-0105,¶¶

(g) Psychiatric Residential Treatment Facilities (PRTF) as defined in OAR 309-022-0105, and¶¶

(h) Residential Substance Use Disorders Treatment Programs as defined in OAR 309-018-0105¶¶

(11) "Adults and Youths Released from Incarceration" means Members released from incarceration within the past 365 calendar days, including those released from state and federal prisons, local correctional facilities, juvenile detention facilities, Oregon Youth Authority closed custody corrections or tribal correctional facilities. Eligibility for HRSN Services shall expire on the 366th calendar day after release from a carceral facility.¶¶

(12) "Advance Directive" means an individual's instructions to an appointed person specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.¶¶

(13) "Adverse determination" means a determination made that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.¶¶

(14) "Adverse Event" means an undesirable and unintentional, though not necessarily unexpected, result of medical treatment.¶¶

(15) "Affiliation" means for provider requesting enrollment or revalidation as an Oregon Medicaid provider any of the following:¶¶

(a) Five (5) percent or greater direct or indirect ownership interest that an individual or entity has in another organization;¶¶

(b) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization;¶¶

(c) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization, either under contract or through some

other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization; includes sole proprietorships;¶

(d) An interest in which an individual is acting as an officer or director of a corporation; or¶

(e) Any payment assignment relationship under 42 CFR 447.10(g).¶

(16) "Agent" means any person who has been delegated the authority to obligate or act on behalf of a provider.¶

(17) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (Department) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)."¶

(18) "All-Inclusive Rate" or "Bundled Rate" means the nursing facility rate established for a facility. This rate includes all services, supplies, drugs, and equipment as described in OAR 411-070-0085 and in the Division's Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340 Payment.¶

(19) "Allied Agency" means local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individuals (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, Area Agencies on Aging (AAAs), and federally recognized American Indian tribes).¶

(20) "Alternative Care Settings" means sites or groups of practitioners that provide care to members under contract with a Managed Care Entity (MCE), including urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities, and outpatient surgical centers.¶

(21) "Ambulance" means a specially equipped and licensed vehicle for transporting sick or injured individuals that meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.¶

(22) "Ambulatory Payment Classification" means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).¶

(23) "Ambulatory Surgical Center (ASC)" means a facility licensed as an ASC by the Authority.¶

(24) "American Indian/Alaska Native (AI/AN)" means a member of a federally recognized Indian tribe, band, or group, and an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.¶

(25) "American Indian/Alaska Native (AI/AN) Clinic" means a clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).¶

(26) "Ancillary Services" means services supportive of or necessary for providing a primary service, such as anesthesiology, which is an ancillary service necessary for a surgical procedure.¶

(27) "Anesthesia Services" means administration of anesthetic agents to cause loss of sensation to the body or body part.¶

(28) "Appeal" means a request for review of an adverse determination, action or as it relates to an MCE an adverse benefit determination.¶

(29) "Area Agency on Aging (AAA)" means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS chapter 410 in planning and providing services to the elderly or elderly and disabled population.¶

(30) "Asynchronous" means not simultaneous or concurrent in time. For the purpose of this general rule, asynchronous telecommunication technologies for telemedicine or telehealth services may include audio and video, audio without video, client or member portal and may include remote monitoring. "Asynchronous" does not include voice messages, facsimile, electronic mail or text messages.¶

(31) "At Risk of Homelessness" means a Member who:¶

(a) Has an income that is 30 percent or less than the area median income where the individual resides according to the most recent available data from the U.S. Department of Housing and Urban Development; and,¶

(b) Lacks sufficient resources or support networks to prevent their homelessness; and,¶

(c) Meets any HRSN Housing and Nutrition Clinical Risk Factor as further defined in OAR 410-120-2005 in Tables 2-3.¶

(d) At Risk of Homelessness does not include individuals in Category 1 of the HUD Homeless definition (24 CFR 91.5 (1)). Category 1 (also called "literally homeless") includes people residing in Transitional Housing, as defined in 24 CFR 578.3. Recovery Housing is not Transitional Housing, and a Member in Recovery Housing may be eligible for HRSN Housing Supports.¶

(32) "Atypical Provider" means an entity able to enroll as a Billing Provider (BP) or rendering provider for medical

assistance programs related non-health care services but that does not meet the definition of health care provider for National Provider Identification (NPI) purposes.¶¶

(33) "Audiologist" means an individual licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.¶¶

(34) "Audiology" means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.¶¶

(35) "Audio only" means the use of audio technology, permitting real-time communication between a health care provider and a member for the purpose of diagnosis, consultation or treatment. "Audio only" does not include health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care provider, such as the sharing of laboratory results.¶¶

(36) "Automated Voice Response (AVR)" means a computer system that provides information on clients' current eligibility status from the Division by computerized phone response.¶¶

(37) "Behavioral Health" means mental health, mental illness, addiction disorders, and substance use disorders.¶¶

(38) "Behavioral Health Assessment" means a qualified mental health professional's determination of a member's need for mental health services.¶¶

(39) "Behavioral Health Case Management" means services provided to members who need assistance to ensure access to mental health benefits and services from local, regional, or state allied agencies or other service providers.¶¶

(40) "Behavioral Health Evaluation" means a psychiatric or psychological assessment used to determine the need for mental health or substance use disorder services.¶¶

(41) "Benefit Package" means the package of covered health care services for which the client is eligible.¶¶

(42) "Billing Agent or Billing Service" means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.¶¶

(43) "Billing Provider (BP)" means an individual, agent, business, corporation, clinic, group, institution, or other entity who submits claims to or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.¶¶

(44) "Buying Up" means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See OAR 410-120-1350 Buying Up.)¶¶

(45) "By Report (BR)" means services designated, as BR requires operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care shall facilitate evaluation.¶¶

(46) "Care Coordination" means the act and responsibility of care coordination entities to deliberately organize a client's services, care activities and information sharing among all participants involved with a client's care according to the physical, developmental, behavioral, dental, and social needs (including Health Related Social Needs and Social Determinants of Health and Equity) of the client. Care Coordination requirements are described in OAR 410-120-1215, 410-120-1221, 410-120-1225, and in accordance with CFR 438.208.¶¶

(47) "Care Plan" means a care plan that is developed for and in collaboration with the member, their family, representatives or guardian; and in consultation with the member's providers, community supports and services, where applicable, to ensure continuity and coordination of a member's care according to their needs.¶¶

(48) "Care Profile" means the electronic record the Authority or its designee develops and maintains for all members. The care profile is the platform that receives feeds from different data sources used to identify, track and manage a member's needs and risk level to direct the frequency of the outreach and care coordination activities/opportunities that shall be offered to the member.¶¶

(49) "Case Management Services" means services provided to ensure that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency, or dental services, referring members to community services and supports that may include referrals to Allied Agencies.¶¶

(50) "Center of Excellence (COE)" means a hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.¶¶

(51) "Child Welfare (CW)" means a division within the Department responsible for administering child welfare programs, including child abuse investigations and intervention, foster care, adoptions, and child safety.¶¶

(52) "Children's Health Insurance Program (CHIP)" means a federal and state funded portion of the Oregon Health

Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.¶¶

(53) "Chiropractor" means an individual licensed to practice chiropractic by the relevant state licensing board.¶¶

(54) "Chiropractic Services" means services provided by a licensed chiropractor within the scope of practice as defined under state law and federal regulation.¶¶

(55) "Citizenship Waived Medical (CWM) Benefit Package" means the coverage and limitations defined in OAR 410-134-0005(2) for individuals who met the eligibility requirements in OAR 410-200-0240(1).¶¶

(56) "Citizenship Waived Medical Plus (CWX) Benefit Package" means coverage and limitations described in OAR 410-134-0005(2) for CWM individuals who were pregnant or in their post-partum period and meet the eligibility requirements defined in OAR 410-200-0240(2).¶¶

(57) "Claimant" means an individual who has requested a hearing.¶¶

(58) "Client" means an individual found eligible to receive OHP health services.¶¶

(59) "Clinical Nurse Specialist" means a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.¶¶

(60) "Clinical Social Worker" means an individual licensed to practice clinical social work pursuant to state law.¶¶

(61) "Clinical Record" means the medical, dental, or mental health records of a client or member.¶¶

(62) "Clinically Appropriate" means having at least one HRSN Clinical Risk Factor and at least one HRSN Social Risk Factor, each of which must be applicable to the HRSN Service for which the Member is authorized. For example, to determine whether a Member must be authorized to receive Home Changes for Health-Related Supports, the Member must, in addition to belonging to an HRSN Covered Population, have at least one HRSN Clinical Risk Factor and one HRSN Social Risk Factor. HRSN Services are not Clinically Appropriate if they are solely for the convenience or preference of the Member.¶¶

(63) "Closed Loop Referral" means the process of exchanging information between and among an MCE, the Oregon Health Authority (which may include its Fee For Service (FFS) Program), a Member, HRSN Service Providers, and other similar organizations, to make referrals and communicate about the status of referrals and services for a Member.¶¶

(64) "Comfort Care" means medical services or items that give comfort or pain relief to an individual who has a terminal illness, including the combination of medical and related services designed to make it possible for an individual with terminal illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.¶¶

(65) "Community Health Worker" means an individual who:¶¶

- (a) Has expertise or experience in public health;¶¶
- (b) Works in an urban or rural community either for pay or as a volunteer in association with a local health care system;¶¶
- (c) To the extent practicable, shares ethnicity, language, socioeconomic status, and life experiences with the residents of the community where the worker serves;¶¶
- (d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;¶¶
- (e) Advocates for the individual patient and community health needs, building individual and community capacity to advocate for their health;¶¶
- (f) Provides health education and information that is culturally appropriate to the individuals being served;¶¶
- (g) Assists community residents in receiving the care they require;¶¶
- (h) May give peer counseling and guidance on health behaviors; and¶¶
- (i) May provide direct services such as first aid or blood pressure screening.¶¶

(66) "Community Information Exchange" and "CIE" each means a technology system used by a network of collaborative partners to exchange information for the purpose of connecting individuals to the services and supports they need. CIE functionality must include Closed Loop Referrals, a shared resource directory, and documentation of consent to the use of technology by the Member or other individual being connected to services.¶¶

(67) "Community Mental Health Program (CMHP)" means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority.¶¶

(68) "Community Partner" means an individual affiliated with an organization contracted, trained, and certified by the Oregon Health Authority's Community Partner Outreach Program to provide free assistance to people applying for health coverage in Oregon that includes but is not limited to:¶¶

- (a) Health coverage application;¶¶
- (b) Help to enroll in health insurance plans;¶¶
- (c) Health coverage renewal assistance;¶¶
- (d) Healthcare System Navigation defined in OAR 410-120-0000; and¶¶

- (e) Outreach and engagement related to subsections (a) through (d) of this section (6).¶
- (69) "Co-morbid Condition" or "Comorbidity" means a medical condition or diagnosis coexisting with one or more other current and existing conditions or diagnoses in the same patient.¶
- (70) "Condition-Specific Program" and "Condition-Specific Facility" mean programs or facilities that treat a narrowly defined illness, disorder or condition, such as:¶
- (a) Behavioral and Mental Health conditions, Substance Use Disorder (SUD) or addiction, including but not limited to:¶
 - (A) Alcohol;¶
 - (B) Illicit drugs; and¶
 - (C) Gambling.¶
 - (b) Physical Health conditions, including but not limited to:¶
 - (A) Cancer;¶
 - (B) Diabetes;¶
 - (C) Bariatric Care.¶
 - (c) Developmental Disabilities.¶
- (71) "Condition/Treatment Pair" means diagnoses described in the International Classification of Diseases Clinical Modifications, 10th edition (ICD-10-CM); the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5; and treatments described in the Current Procedural Terminology (CPT); or American Dental Association Codes (CDT) or the Authority Behavioral Health Fee Schedule, that, when paired by the Health Evidence Review Commission (HERC), constitute the line items in the OHA Prioritized List of Health Services. Condition/~~T~~ Treatment Pairs may contain many diagnoses and treatments.¶
- (72) "Contested Case Hearing" means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an adverse determination, action, or as it relates to an MCE enrollee, an adverse benefit determination:¶
- (a) A client or member or their representative;¶
 - (b) A member of an MCE after resolution of the MCE's appeal process;¶
 - (c) An MCE member's provider; or¶
 - (d) An MCE.¶
- (73) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.¶
- (74) "Contiguous Area Provider" means a provider practicing in a contiguous area.¶
- (75) "Continuing Treatment Benefit" means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client's benefit package changed to one that does not cover the treatment.¶
- (76) "Coordinated Care Organization (CCO)" has the meaning given that term in OAR 410-141-3500(21).¶
- (77) "Co-Payments" means the portion of a claim or medical, dental, or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See OAR 410-120-1230 Client Copayment.)¶
- (78) "Cost Effective" means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.¶
- (79) "Cover All Kids (CAK)" meaning defined in OAR 410-200-0015.¶
- (80) "Covered Services" means ~~medically necessary and appropriate~~ health services and items described in ORS chapter 414 and applicable administrative rules. Covered services include:¶
- (a) Services described in the OHA Prioritized List of Health Services ~~above the funding line set by the legislature;~~¶
 - (b) Ancillary Services OAR 410-120-0000 (226);¶
 - (c) Diagnostic Services OAR 410-120-0000 (82);¶
 - (d) Services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in Code of Federal Regulations (CFR) 42 CFR part 438, subpart k; and¶
 - (e) Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as described in chapter 410 division 151.¶
- (81) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.¶
- (82) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association used to report medical, surgical, and diagnostic procedures and services performed by physicians and other health care providers.¶
- (83) "Credible Allegation of Fraud" means an allegation for fraud, which has been verified by the Authority or delegate, from any source, including but not limited to: fraud hotline complaints, claims data mining, and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have the indicia of reliability and the Agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.¶

- (84) "Date of Receipt of a Claim" means the date on which the Authority receives a claim as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.¶¶
- (85) "Date of Service" means the date on which the client receives medical services or items, unless otherwise specified in the appropriate provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.¶¶
- (86) "Deactivation" means an action prohibiting a provider's participation where the Authority assigned provider number is terminated as the result of inactivity, as evidenced by failure to submit claims for eighteen (18) months, or relocation, as evidenced by returned/undeliverable mail by the United States Postal Service or any other mail carrier.¶¶
- (87) "Declaration for Mental Health Treatment" means a written statement of an individual's decisions concerning their mental health treatment. The individual makes the declaration when they are able to understand and make decisions related to treatment that is honored when the individual is unable to make such decisions.¶¶
- (88) "Dental Emergency Services" means dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.¶¶
- (89) "Dental Subcontractor" means a prepaid managed care health services organization that enters into a noncomprehensive risk contract with a coordinated care organization (CCO) or the Authority to provide dental services to their Members or, as applicable, Clients enrolled in OHP. Dental Subcontractors contracting with CCOs must perform all delegated activities in accordance with OAR 410-141-3505.¶¶
- (90) "Dental Therapist" means a person licensed to practice dental therapy within the scope of practice as defined under state law.¶¶
- (91) "Dentist" means an individual licensed to practice dentistry pursuant to state law of the state in which they practice dentistry or an individual licensed to practice dentistry pursuant to federal law for the purpose of practicing dentistry as an employee of the federal government.¶¶
- (92) "Denturist" means an individual licensed to practice denture technology pursuant to state law.¶¶
- (93) "Denturist Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a denturist.¶¶
- (94) "Dental Hygienist" means an individual licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to state law.¶¶
- (95) "Dental Hygienist with an Expanded Practice Permit" means an individual licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to state law.¶¶
- (96) "Dentally Appropriate"¶¶
- (a) means dental services, items or dental supplies that are:¶¶
 - (A) Recommended by a licensed health provider practicing within the scope of their license; and¶¶
 - (B) Safe, effective and appropriate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and¶¶
 - (C) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply; and¶¶
 - (D) The most cost effective of the alternative levels or types of health services, items or supplies that are covered services that can be safely and effectively provided to a client or member in the Division or MCE's judgment.¶¶
 - (b) All covered services must be dentally appropriate for the member or client but not all medically appropriate services are covered services.¶¶
 - (c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410, division 151.¶¶
- (97) "Oregon Department of Human Services (Department or ODHS)" means the agency established in ORS chapter 409, including such divisions, programs and offices as may be established therein.¶¶
- (98) "Department Representative" means an individual who represents the Department and presents the Department's position in a hearing.¶¶
- (99) "Diagnosis Code" means as identified in the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM). The primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rules. Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.¶¶
- (100) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-10-CM.¶¶
- (101) "Diagnostic Services" mean those services required to diagnose a condition, including but not limited to: radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.¶¶
- (102) "Dietitian" means an individual licensed by the Board of Licensed Dietitians to provide nutrition services as

outlined in the Standards of Practice in the OR Administrative Rules, chapter 834, division 60 (OAR 834-060-0000).¶¶

(103) "Division" means the Health Systems Division within the Authority. The Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP-Title XXI), and several other programs.¶¶

(104) "Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches, and custom-built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.¶¶

(105) "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means the program requiring specific coverage for children and young adults, as described in chapter 410 division 151.¶¶

(106) "Electronic Data Interchange (EDI)" means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules OAR 943-120-0100 through OAR 943-120-0200, EDI does not include electronic transmission by web portal.¶¶

(107) "EDI Submitter" means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.¶¶

(108) "Electronic Verification System (EVS)" means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.¶¶

(109) "Emergency Department" means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.¶¶

(110) "Emergency Health Benefit Funding" means funding for the health benefits defined in OAR 410-134-0004(2)(a-j), included in the Healthier Oregon benefits package that is in part funded with state funding and matched with federal funds (42 CFR 440.255).¶¶

(111) "Emergency Medical Condition" means a medical condition, whether physical, dental, or behavioral, manifesting itself by acute symptoms of sufficient severity such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to the pregnant person, the health of the person or their pregnancy) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An emergency medical condition is not based on the final diagnosis but is based on presenting symptoms as perceived by a prudent layperson and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.¶¶

(112) "Emergency Medical Transportation" means transportation necessary for a client with an emergency medical condition as defined in this rule and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.¶¶

(113) "Emergency Services" means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.¶¶

(114) "Evidence-Based Medicine" means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate evaluation of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)). In addition, Evidence-Based Medicine considers the quality of evidence and the confidence that may be placed in findings.¶¶

(115) "False Claim" means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading, or omitted information and such inaccurate, misleading, or omitted information may result,

or has resulted, in an overpayment.¶¶

(116) "Family Planning Services" means services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and that are intended to prevent pregnancy or otherwise limit family size.¶¶

(117) "Federally Supported Hemophilia Treatment Center" means a hemophilia treatment center (HTC) that:¶¶

(a) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program;¶¶

(b) Is qualified to participate in 340B discount purchasing as an HTC;¶¶

(c) Actively participates in the U.S. Center for Disease Control (CDC) and Prevention surveillance and has an identification number that is listed in the HTC directory on the CDC website;¶¶

(d) Is recognized by the Federal Regional Hemophilia Network that includes the State of Oregon; and¶¶

(e) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.¶¶

(118) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity that receives grants under Section 329, 330, or 340 of the Public Health Service Act or a facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.¶¶

(119) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of an Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP). A medical provider participating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.¶¶

(120) "For Cause Termination" means a mandatory or discretionary termination by the Authority as is outlined in OAR 410-120-1400.¶¶

(121) "Fraud" means an intentional deception or misrepresentation made by an individual with the knowledge that the deception may result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.¶¶

(122) "Fruit and Vegetable Benefit" means a service that allows a HRSN Fruit and Vegetable Authorized Member (as that term is defined in this rule) to obtain or otherwise receive fruits and vegetables, including herbs, from an HRSN Service Vendor or HRSN Service Provider. The Fruit and Vegetable Benefit includes fresh, frozen, pureed, dried or canned (or any combination of fresh, frozen, dried, pureed or canned) fruits and vegetables, as well as herbs. The Fruit and Vegetable Benefit is one of several discrete benefits that comprise the Nutrition-Related Supports, which is an HRSN Service.¶¶

(123) "Fruit and Vegetable Benefit Card" means a service that allows an HRSN Fruit and Vegetable Authorized Member to purchase the Fruit and Vegetable Benefit from participating food retailers, vendors, or farms, or any combination of them, while utilizing an approved Fruit and Vegetable Benefit retail card obtained from a vendor that is enrolled with OHA as an HRSN Service Provider.¶¶

(124) "Fruit and Vegetable Box" means one of the Fruit and Vegetable Benefits that consists of pre-selected, pre-packaged fruit and vegetables that an HRSN Fruit and Vegetable Authorized Member obtains from an HRSN Fruit and Vegetable Service Vendor or Service Provider. Depending on which HRSN Fruit and Vegetable Service Vendor or Service Provider a CCO or the Authority works with, the HRSN Fruit and Vegetable Authorized Member may have the Fruit and Vegetable Box delivered to them by the HRSN Fruit and Vegetable Service Vendor or, if available, the Member may be able to pick up the box from the HRSN Fruit and Vegetable Service Vendor or HRSN Service Provider.¶¶

(125) "Fully Dual Eligible" means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Authority for full medical assistance coverage.¶¶

(126) "General Assistance (GA)" means medical assistance administered and funded 100 percent with State of Oregon funds through OHP.¶¶

(127) "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.¶¶

(128) "Health Care Interpreter" Certified or Qualified have the meaning given those terms in ORS 413.550.¶¶

(129) "Health Care Professionals" means individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.¶¶

(130) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level I - American Medical Association's Physician's Current Procedural Terminology (CPT), Level II - National codes, and Level III - Local codes. The

Division uses HCPCS codes; however, the Division uses current Dental Terminology (DT) codes for the reporting of dental care services and procedures.¶¶

(131) "Healthcare System Navigation" means the process by which a Community Partner supports individuals who are in need of health care by:¶¶

(a) Assisting with application for or renewal of Oregon Health Plan (OHP);¶¶

(b) Assisting with the management of the application process for OHP;¶¶

(c) Assisting with accessing available benefits;¶¶

(d) Identifying and removing barriers to care;¶¶

(e) Providing the information needed to build the knowledge and confidence necessary for utilizing benefits; or¶¶

(f) Promoting the establishment of healthcare services and continuity of care.¶¶

(132) "Health Evidence Review Commission" means a commission that, among other duties, develops and maintains a list of health services ranked by priority from the most to the least important representing the comparative benefits of each service to the population served.¶¶

(133) "Health Insurance Portability and Accountability Act of 1996 (HIPAA)" means the federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.¶¶

(134) "Health Maintenance Organization (HMO)" means a public or private health care organization that is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.¶¶

(135) "Health Plan New/non-categorical client (HPN)" means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program, and who must meet all eligibility requirements to become an OHP client.¶¶

(136) "Healthier Oregon" means the medical assistance benefit package that is equal to the OHP Plus benefit package defined in OAR 410-120-1210. The Healthier Oregon is for individuals;¶¶

(a) Who do not meet the citizenship and non-citizen status requirements defined in OAR 410-200-0215 and OAR 461-120-0110; and¶¶

(b) Who do meet the financial and other non-financial eligibility requirements for a Health Systems Division (HSD) Medical Program (see OAR chapter 410 division 200) or an Oregon Supplemental Income Program Medical (OSIPM) Program (see OAR chapter 461).¶¶

(137) "Health-Related Social Needs" and "HRSN" each means the unmet, housing, nutrition, and outreach and engagement-related social needs, that contribute to an individual's poor health and are a result of underlying social and structural determinants of health.¶¶

(138) "Health Risk Assessment (HRA)" means a survey or questionnaire administered verbally, digitally or in writing, to collect information from a member, their representative or guardian about key areas of the member's health, including their physical, developmental, behavioral, oral and social needs (including Health Related Social Needs and Social Determinants of Health and Equity). The HRA is intended to inform the coordination of services and supports that meet the members individualized needs.¶¶

(139) "Hearing Aid Dealer" means an individual licensed by the Board of Hearing Aid Dealers to sell, lease, or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.¶¶

(140) "HERC Prioritized List of Health Services" means the listing of condition and treatment pairs, together with diagnosis and treatment codes, guideline notes, ancillary guideline notes, diagnostic guideline notes, excluded services guideline notes, statements of intent, and coding specifications and annotations, developed by the Health Evidence Review Commission for the purpose of advising the Authority on the administration of the Oregon Health Plan and the OHA Prioritized List of Health Services.¶¶

(141) "Home Changes for Health During Extreme Weather Supports" means health-related devices delivered, and as applicable installed or serviced (or both) by HRSN Service Vendors or HRSN Service Providers in the home of an HRSN-Home Changes for Health Authorized Member (as that term is defined in this rule). "Home Changes for Health" has the same meaning.¶¶

(a) Clinically Appropriate home changes for health devices include:¶¶

(A) Air conditioners for individuals at health risk due to significant heat;¶¶

(B) Heaters for individuals at increased health risk due to significant cold;¶¶

(C) Air filtration devices and, as needed, replacement air filters for individuals at health risk due to compromised air quality;¶¶

(D) Mini refrigeration units as needed for individuals to store their medications; and¶¶

(E) Portable power supplies (PPSs) for individuals who utilize and need to have access to medically necessary electricity-dependent equipment (e.g., ventilators, dialysis machines, intravenous equipment, chair lifts, mobility devices, communication devices, etc.) or are at risk of public safety power shutoffs that could prevent or interfere

with their ability to use medically necessary devices.¶¶

(b) Home Changes for Health services include, as may be needed by the Member, the provision and service delivery, and, as needed, installation of all the Home Changes for Health devices (identified in (a)(A)- (E) above in this rule) and device maintenance.¶¶

~~(1412)~~ "Home Changes for Safety" means home modifications or remediations that are made by an HRSN Services Vendor for the purpose of eliminating known home-based health and safety risks and ensuring the HRSN Home Changes for Safety Authorized Member's living environment meets that Member's functional, health, or safety needs. The term "Home Modifications and Remediations" has the same meaning.¶¶

~~(1423)~~ "Home Enteral Nutrition" means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.¶¶

~~(1434)~~ "Home Health Agency" means a public or private agency or organization that has been certified by Medicare as a Medicare home health agency and that is licensed by the Authority as a home health agency in Oregon and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.¶¶

~~(1445)~~ "Home Health Services" means part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.¶¶

~~(1456)~~ "Home Intravenous Services" means services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.¶¶

~~(1467)~~ "Home Parenteral Nutrition" means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.¶¶

~~(1478)~~ "Hospice" means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation and is currently licensed by the Oregon Health Authority, Public Health Division.¶¶

~~(1489)~~ "Hospital" means a facility licensed by the Public Health Division as a general hospital that meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals shall be considered hospitals for reimbursement purposes if they are licensed as a short-term acute care or general hospital by the appropriate licensing authority within that state and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.¶¶

~~(14950)~~ "Hospital-Based Professional Services" means professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (DMAP 42) report for the Division.¶¶

~~(1501)~~ "Hospital Dentistry" means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center or inpatient or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).¶¶

~~(1512)~~ "Hospital Laboratory" means a laboratory providing professional technical laboratory services as outlined under laboratory services in a hospital setting as either an inpatient or outpatient hospital service whose costs are reported on the hospital's cost report to Medicare and to the Division.¶¶

~~(1523)~~ "Housing-Related Supports" means housing services provided to Members authorized to receive one or more of the HRSN Housing-Related Supports service categories to help them maintain healthy and safe housing (as detailed in OAR 410-120-2005). Housing-Related Supports include:¶¶

(a) Rent and Utility financial assistance (past due and prospective)¶¶

(b) Hotel/Motel Stays¶¶

(c) Utilities Arrears¶¶

(d) Utilities Set Up¶¶

(e) Storage Fees (past due and prospective)¶¶

(f) Tenancy Services (paid via 15-minute increments)¶¶

(g) Tenancy Services (paid per member per month)¶¶

(h) Home Changes for Safety¶¶

(i) Home Changes for Health¶¶

~~(1534)~~ "HRSN Authorized Member" means a Member who has participated in an HRSN Eligibility Screening and

has been approved by the MCE or, as applicable, the Authority, to receive one or more HRSN Services. Members who have been authorized for a specific HRSN Service may be identified by the specific HRSN service or benefit that they have been authorized to receive such as, without limitation, "HRSN Fruit and Vegetable Authorized Member" or "HRSN Rent and Utility Authorized Member" or "HRSN Tenancy Supports Authorized Member."¶¶ (1545) "HRSN Clinical Risk Factor" is the generic term to describe the clinical risk a Member must have in order to be eligible for an HRSN service. All HRSN Clinical Risk Factors are identified in OAR 410-120-2005 in Tables 1 through 3 and include the following:¶¶

(a) Table 1: Home Changes for Health Device-Specific and Outreach and Engagement Clinical Risk Factors¶¶

(b) Table 2: Home Modifications and Remediations, Tenancy Supports, Nutrition Supports, and Outreach and Engagement Clinical Risk Factors¶¶

(c) Table 3: Rent and Utility Financial Assistance and Outreach and Engagement Clinical Risk Factors¶¶

(1556) "HRSN Connector" means any person or entity, including HRSN Service Providers and other similar social service organizations, that assists Members in documenting the information necessary to make an HRSN Request to an MCE for an HRSN Eligibility Screening and HRSN Service authorization.¶¶

(1567) "HRSN Covered Populations" means Members, excluding Members receiving the BRG service package defined in OAR 410-115-0030, who belong to one or more of the following populations, which are further defined in this OAR 410-120-0000:¶¶

(a) Adults and Youth Discharged from an Institution for Mental Diseases (IMD); residential mental health and substance use disorder facility, or inpatient psychiatric unit¶¶

(b) Adults and Youth Released from Incarceration¶¶

(c) Individuals currently or previously involved in Oregon's Child Welfare system¶¶

(d) Individuals Transitioning to Dual Medicaid and Medicare Status¶¶

(e) Individuals who meet the definition of "HUD Homeless"¶¶

(f) Individuals who meet the definition of "At Risk of Homelessness"¶¶

(g) Individuals identified as "Young Adults with Special Health Care Needs"¶¶

(1578) "HRSN Eligibility Screening" means the process set out in OAR 410-120-2015, followed by MCEs or, as applicable, the Authority to determine whether a Member meets the criteria necessary for authorizing an HRSN Service.¶¶

(1589) "HRSN Eligible" means a Member, except for Members receiving the BRG service package defined in OAR 410-115-0030, who meets all of the following criteria:¶¶

(a) Belongs to at least one of the HRSN Covered Populations,¶¶

(b) Has at least one HRSN Clinical Risk Factor applicable to the HRSN Services,¶¶

(c) Has at least one HRSN Social Risk Factor applicable to the HRSN Services, and¶¶

(d) Meets any additional eligibility criteria and requirements that may apply to a specific HRSN Service all of which are identified in OAR 410-120-2005.¶¶

(15960) "HRSN Fee Schedule" means the comprehensive list of rates that establishes the maximum allowable reimbursement amount for each HRSN Service. Each service is associated with a unique procedure code and a corresponding procedure code modifier, which are used to correctly identify each service for billing purposes.¶¶

(1601) "HRSN Outreach and Engagement Services (HRSN O&E Services)" means the activities performed by HRSN Service Providers, the Authority, or MCEs as described in OAR 410-120-2005. HRSN Service Providers shall be compensated for providing HRSN O&E Services when provided to "Presumed HRSN Eligible" Members as described in OAR 410-120-2005.¶¶

(1612) "HRSN Person-Centered Service Plan" and "HRSN PCSP" each means the HRSN-related component of the care plan that is developed in consultation with the Member upon authorization of HRSN Services as described in OAR 410-120-2025.¶¶

(1623) "HRSN Self-Attestation" and "Self-Attestation" means an oral or written statement made by the Member or Member Representative that the Member satisfies the applicable requirements necessary to establish the Member is HRSN Eligible to receive one or more HRSN Services. Also see OAR 410-120-2015.¶¶

(1634) "HRSN Service Provider" means a private or public social service organization, community organization, or other similar individual or entity that provides HRSN Services and meets the qualifications outlined in OAR 410-120-2030 as applicable.¶¶

(1645) "HRSN Service Request(s)" and "HRSN Request" means a request from an HRSN Connector (an organization or an individual) made to an MCE or, as applicable, the Authority, for the purpose of requesting that the MCE, or as applicable, the Authority, perform an HRSN Eligibility Screening. Some HRSN Requests will be considered complete when the HRSN Connector identifies (i) the name and contact information of the individual who wants to be screened for an HRSN Service and (ii) the anticipated HRSN Service need; however, as described in OAR 410-120-2010, other HRSN Requests will need to identify other information in addition to the name, contact information, and HRSN Service need in order to be considered complete. HRSN Requests may also include confirmation of OHP enrollment, including confirmation of MCE or FFS enrollment, as well as any other

information regarding the individual's potential HRSN Eligibility. The MCE or, as applicable, the Authority, shall be required to document its attempts to collect the information needed to determine eligibility.¶

(1656) "HRSN Service Vendor" means any individual or entity that is contracted or procured by the Authority, an MCE, or an HRSN Service Provider to deliver or provide HRSN Services directly to an HRSN Eligible Member who has been approved to receive HRSN Services. HRSN Service Vendors do not provide HRSN O&E and Tenancy Services. All HRSN Service Vendors that contract directly with the Authority must be enrolled as a Medicaid HRSN Service Provider in accordance with the applicable provisions OAR 410-120-1260. Examples of HRSN Service Vendors include, without limitation, entities, individuals, or organizations that deliver or install air conditioners, heaters, air filtration devices, Portable Power Supplies (PPSs) or mini refrigeration units, as well as home modification vendors, landlords, hotels/motels, chore service providers, utilities and moving companies, pest eradication companies and storage facilities, organizations that assess Members for, plan, prepare, or deliver Medically Tailored Meals and organizations that coordinate, deliver, provide an array of Fruit and Vegetable produce services, and provide an array of Pantry Stocking services including, but not limited to, prepaid produce cards as applicable, usage of vouchers, associated internet platforms, delivery of produce, and produce box programs.¶

(1667) "HRSN Services" means any one of the Home Changes for Health Housing-Related Supports, Nutrition-Related Supports, or HRSN Outreach and Engagement services that address a Member's Health-Related Social Needs. Additional information regarding the different components of HRSN Services are detailed in OAR 410-120-2005 Tables 4-10 The term "HRSN Benefits" has the same meaning.¶

(1678) "HRSN Social Risk Factor" means the need(s) of a Member related to a Health-Related Social Needs service. The HRSN Social Risk Factors are specific to each of the HRSN Services, which are Home Changes for Health, Housing-Related Supports, Nutrition-Related Supports, and Outreach and Engagement Services. HRSN Social Risk Factors are the following:¶

(a) HRSN Home Changes for Health Social Risk Factor: A Member who requires a qualifying device to treat, improve, stabilize, or prevent their HRSN Clinical Risk Factor.¶

(b) HRSN Housing-Related Social Risk Factor: A Member who (i) meets the HUD homeless definition as defined in OAR 410-120-0000, or (ii) is at risk of homelessness as defined in OAR 410-120-0000, or (iii) requires a home modification or remediation service to treat, improve, stabilize, or prevent their HRSN Clinical Risk Factor.¶

(c) HRSN Nutrition-Related Social Risk Factor: A Member who meets the USDA definition of low food security or very low food security as defined in this OAR 410-120-0000.¶

(d) HRSN Outreach and Engagement Social Risk Factor: A Member who requires support to obtain or maintain connection with benefit programs, services, or supports for basic needs.¶

(1689) "HUD Homeless" has the meaning assigned to it by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR § 91.5.¶

(16970) "Imminent Eviction" means a tenant has received a court summons or documentation of a similar nature indicating that the eviction process has been initiated.¶

(1701) "Indian Health Care Provider" (IHCP) means an Indian health program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or an urban Indian organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).¶

(1712) "Indian Health Program" means any Indian Health Service (IHS) facility, any federally recognized tribe or tribal organization, or any FQHC with a 638 designation.¶

(1723) "Indian Health Service (IHS)" means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized tribes and Alaska Natives.¶

(1734) "Indian Managed Care Entities" (IMCE) means a CCO, MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which may also include the Service.¶

(1745) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602), individuals with-out health insurance coverage, public or private, who meet standards for indigence adopted by the federal government as defined in ORS 813.602(5).¶

(1756) "Individual Adjustment Request Form (OHP 1036)" means a form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.¶

(1767) "Individuals Involved with Child Welfare" means Members who are currently, or have previously been, involved in Oregon's Child Welfare System including Members who are currently or have previously been:¶

(a) In foster/substitute care;¶

(b) The recipient of adoption or guardianship assistance;¶

(c) Served on an in-home plan; or¶

(d) The subject of an open child welfare case.¶

(1778) "Individuals Transitioning to Dual Status" means Members enrolled in Medicaid who are transitioning to Fully Dual Eligible as defined in this rule. Members who are Individuals Transitioning to Dual Status shall be included in HRSN Covered Population for the ninety (90) calendar days preceding the date Medicare coverage is to take effect and 270 calendar days after it takes effect.¶

(1789) "Inpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)¶

(17980) "Institutional Level of Income Standards (ILIS)" means three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and individuals on ICF/IID waivers or eligibility for services under Aging and People with Disabilities (APD) Home and Community Based Services program.¶

(1801) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing or hospital care for a period of thirty (30) days or more.¶

(1842) "International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (including volumes 1, 2, and 3, as revised annually)" means a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.¶

(1823) "Joint Fair Hearing Request" means a request for a fair hearing that is included in an appeal request submitted to an Exchange or other insurance affordability program or appeals entity, in accordance with the signed agreement between the agency and an Exchange or Exchange appeals entity or other program or appeals entity described in 42 CFR 435.1200.¶

(1834) "Laboratory" means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare and to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of or the assessment of the health of human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory under the Clinical Laboratory Improvement Act (CLIA).¶

(1845) "Laboratory Services" means those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within their scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent laboratory.¶

(1856) "Letter of Medical Necessity (LMN)" means a letter written by the treating provider requesting Prior Authorization for an OHP service covered under the State Plan that is not presumptively Medically Necessary or Medically Appropriate based on a CCO's or the Authority's applicable clinical practice guidelines, including but not limited to the OHA Prioritized List of Health Services (OHA Prioritized List), including the applicable guideline notes, statements of intent and other applicable Medical Necessity criteria, but the treating provider is of the opinion, based on their professional, clinical judgment, that the OHP service is Medically Necessary and Medically Appropriate for the individual Member. An LMN must, but is not required to:¶

(a) Describe with specificity:¶

(A) The specific value and necessity of the treatment or service in relation to the Member's condition, including any Comorbidities:¶

(B) Why other treatments or services on the OHA Prioritized List have not been or will not be effective; and¶

(C) Why the requested treatment or services on the OHA Prioritized List will improve, cure, provide relief from, or reduce in severity or time, the condition, including the quantity, frequency, and duration of the treatment of service and how it will lead to measurable improvement.¶

(b) Include:¶

(A) Information regarding previous treatments and services prescribed to treat the Member's condition that are relevant to the current request; and¶

(B) Any available clinical literature supporting the use of the requested treatment or service.¶

(187) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered or legally licensed to practice midwifery by the Public Health Division.¶

(1868) "Liability Insurance" means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.¶

(1879) "Long-Term Acute Care (LTAC) Hospital" means a facility that provides specialty care designed for patients with serious medical problems that require intense, special treatment for an extended period of time.¶

~~(18890)~~ "Long-term Care or Long-term Services and Supports" means Medicaid funded Long-term care or long-term services and supports services that include:¶¶

(a) "Long-term Care" as defined in OAR 461-001-0000 means the system through which the Department of Human Services provides a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and behavioral health care outlined in OAR chapter 410, division 172 Medicaid Behavioral Health, including state psychiatric hospitals;¶¶

(b) "Long-term Services and Supports" means the Medicaid services and supports provided under a CMS approved waiver to assist individual's needs and to avoid institutionalization as defined in OAR chapter 411, Division 4 and defined as Medicaid Home and Community-Based Settings and Services (HCBS) and as outlined in OAR chapter 410, division 172 (Medicaid Payment for Behavioral Health Services).¶¶

~~(1891)~~ "Low Food Security" means reduced quality, variety, or desirability of diet; little or no indication of reduced food intake, as measured by the U.S. Household Food Security Survey Module: Six Item Short Form from the U.S. Department of Agriculture published in May 2024, available here:
<https://www.ers.usda.gov/media/xxsjnqd1/short2024.pdf>¶¶

~~(1902)~~ "Managed Care Entity (MCE)" means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, primary care case managers and Coordinated Care Organizations.¶¶

~~(1913)~~ "Managed Care Organization (MCO)" means a contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging, and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).¶¶

~~(1924)~~ "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of the provider, whether the provider is an individual, institution, organization or agency.¶¶

~~(1935)~~ "Maternity Case Management" means a program available to pregnant clients. The purpose of maternity case management is to extend prenatal services to include non-medical services that address social, economic, and nutritional factors. For more information refer to the Division's Medical-Surgical Services program administrative rules.¶¶

~~(1946)~~ "Meaningful access" means client or member-centered access reflecting the following statute and standards:¶¶

(a) Pursuant to Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act and the corresponding Federal Regulation at 45 CFR Part 92 and The Americans with Disabilities Act (ADA), providers' telemedicine or telehealth services shall accommodate the needs of individuals who have difficulty communicating due to a medical condition, who need accommodation due to a disability, advanced age or who have Limited English Proficiency (LEP) including providing access to auxiliary aids and services as described in 45 CFR Part 92;¶¶

(b) National Culturally and Linguistically Appropriate Services (CLAS) Standards at
<https://thinkculturalhealth.hhs.gov/clas/standards>; and¶¶

(c) As applicable to the client or member, Tribal based practice standards:
<https://www.oregon.gov/OHA/HSD/AMH/Pages/EBP.aspx>;¶¶

(d) "Synchronous" means an interaction between a provider and a client or member that occurs at the same time using an interactive technology. This may include audio only, video only, or audio with video and may include remote monitoring.¶¶

~~(1957)~~ "Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.¶¶

~~(1968)~~ "Medical Assistance Eligibility Confirmation" means verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.¶¶

~~(1979)~~ "Medical Assistance Program" means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project and Medicaid and CHIP services under the State Plan, or Healthier Oregon, or Bridge Program, or any other programs that may be prescribed by the Authority from time to time, in accordance with ORS 414.025(17).¶¶

~~(198200)~~ "Medical Care Identification" means the card commonly called the "medical card" or medical ID issued to clients (called the Oregon Health ID starting Aug. 1, 2012).¶¶

~~(199201)~~ "Medical Services" means care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating, or correcting a medical problem.¶¶

~~(2002)~~ "Medical Transportation" means transportation to or from covered medical services.¶¶

~~(2013)~~ "Medically Appropriate"¶¶

(a) Means health services, items, or medical supplies that are:¶¶

- (A) Recommended by a licensed health provider practicing within the scope of their license; and¶
- (B) Safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence; and¶
- (C) Not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply; and¶
- (D) The most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a Division client or member in the Division or MCE's judgment.¶
- (b) All covered services must be medically appropriate for the member or client, but not all medically appropriate services are covered services.¶
- (c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 division 151.¶
- (2024) "Medically Necessary" means:¶
 - (a) Health services and items that are required to address one or more of the following:¶
 - (A) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that could result in health impairments or a disability; or¶
 - (B) The client's or member's ability to achieve age-appropriate growth and development; or¶
 - (C) The client's or member's ability to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or¶
 - (D) The client's or member's ability to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice, when they are receiving Long Term Services or Supports (as defined in these rules);¶
 - (b) A medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services.¶
 - (c) For Early and Periodic Screening, Diagnostic and Treatment (EPSDT), see chapter 410 division 151.¶
- (2035) "Medically Tailored Meal" means a fully prepared meal comprised of foods that have been identified, in consultation with a registered dietitian nutritionist licensed in the state of Oregon, to meet the specific needs of a Member who has been authorized to receive HRSN Medically Tailed Meals.¶
- (2046) "Medicare" means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:¶
 - (a) Hospital Insurance (Part A) for inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and¶
 - (b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;¶
 - (c) Prescription drug coverage (Part D) means covered Part D drugs that include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act. It also includes medical supplies associated with the injection of insulin. Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.¶
- (2057) "Medical Nutrition Therapy means" an evidence-based application of the Nutrition Care Process provided by licensed dietitians; focused on prevention, delay or management of diseases and conditions; and involving an in-depth assessment, periodic reassessment and intervention(s). (OAR 834-020-0000)¶
- (2068) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.¶
- (2079) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.¶
- (2108) "National Correct Coding Initiative (NCCI)" means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.¶
- (20911) "National Drug Code or (NDC)" means a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages shall display less than 11 digits, but the number assumes leading zeroes.¶
- (2102) "National Provider Identification (NPI)" means federally administered provider number mandated for use on HIPAA covered transactions; individuals, provider organizations, and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI. Medicare and Medicaid covered entities are required to apply for an NPI.¶
- (2143) "Naturopathic physician" means an individual licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.¶
- (2124) "Naturopathic Services" means services provided within the scope of practice as defined under state law

and by rules of the Oregon Board of Naturopathic Medicine.¶¶

~~(2135)~~ "Non-Billing Provider" also referred to as non-payable, means a provider who is issued a provider number for purposes of rendering, ordering, referring, prescribing, data collection, encounters, or non-claims-use of the Provider Web Portal (e.g., eligibility verification).¶¶

~~(2146)~~ "Non-covered Services" means services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in:¶¶

(a) OAR 410-120-1200 Excluded Services and Limitations; and¶¶

(b) OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System;¶¶

(c) OAR 410-141-3820 ~~OHP Benefit Package of Covered Services~~;¶¶

~~(d) OAR 410-141-0520 Prioritized List of Health Service~~ 5 Excluded Services and Limitations; and¶¶

~~(e)~~ Any other applicable Division administrative rules.¶¶

~~(2157)~~ "Non-Emergent Medical Transportation Services (NEMT)" means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000 and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.¶¶

~~(2168)~~ "Nurse Anesthetist, C.R.N.A." means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.¶¶

~~(2179)~~ "Nurse Practitioner" means an individual licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to state law.¶¶

~~(21820)~~ "Nurse Practitioner Services" means services provided within the scope of practice of a nurse practitioner as defined under state law and by rules of the Board of Nursing.¶¶

~~(2219)~~ "Nursing Facility" means a facility licensed and certified by the Department and defined in OAR 411-070-0005.¶¶

~~(2202)~~ "Nursing Services" means health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by state law.¶¶

~~(2243)~~ "Nutrition Care Plan for HRSN Medically Tailored Meals" means a detailed plan created and documented by a dietitian during the Nutrition Care Process that details how Medically Tailored Meals will be used to treat the HRSN Authorized Member's nutrition sensitive health condition. The term "HRSN MTM Nutrition Care Plan" has the same meaning.¶¶

~~(2224)~~ "Nutrition Care Plan for HRSN Pantry Stocking" means the written description of the service, service duration, and service goals incorporated within the HRSN Pantry Stocking Authorized Member's Person Centered Service Plan, as outlined in OAR 410-120-2025 4(a)-(h). The term "HRSN Pantry Nutrition Care Plan" has the same meaning.¶¶

~~(2235)~~ "Nutrition Care Process" means a systematic method that dietetics and nutrition professionals use to provide nutrition care. It is comprised of four steps: nutrition assessment and reassessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation.¶¶

~~(2246)~~ "Nutrition-Related Supports" means nutrition services provided to Members who are authorized to receive one or more of the HRSN Nutrition-Related Supports service categories identified in (a) - (d) of this section, for the purpose of improving their access to food and health (as detailed in OAR 410-120-2005 Table 6). Nutrition-Related Supports include the following:¶¶

(a) Assessment for HRSN Medically Tailored Meals (if not already authorized, performed, and covered by OHP under the Medically Necessary standard);¶¶

(b) Medically Tailored Meals;¶¶

(c) Nutrition Education; and¶¶

(d) Fruit and Vegetable Box and Fruit and Vegetable Benefit Card; and¶¶

(e) Pantry Stocking Grocery Box and Pantry Stocking Grocery Benefit Card¶¶

~~(2257)~~ "Nutritional Counseling" means counseling that takes place as part of the treatment of an individual with a specific condition, deficiency, or disease such as diabetes, hypercholesterolemia, or phenylketonuria.¶¶

~~(2268)~~ "Nutrition Education" means any combination of educational strategies, accompanied by environmental supports, designed to motivate and facilitate voluntary adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being.¶¶

~~(2279)~~ "Occupational Therapist" means an individual licensed by the State Board of Examiners for Occupational Therapy.¶¶

~~(22830)~~ "Occupational Therapy" means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, the aging process, or psychological disability. The treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.¶¶

(231) "OHA Prioritized List of Health Services" means the services identified in the State Medicaid Plan which are listed on the same line with one or more conditions (Condition-Treatment Pairs), together with diagnosis and treatment codes, guideline notes, ancillary guideline notes, diagnostic guideline notes, excluded services guideline notes, statements of intent, coding specifications and annotations, all of which have been identified and recommended by the Health Evidence Review Commission for the purpose of supporting the Authority in the administration of the Oregon Health Plan.

(232) "Ombudsman Services" means advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of, or limitations on the health services provided.

(233) "Oregon Health ID" means a card the size of a business card that lists the client's name, client ID (prime number), and the date it was issued.

(234) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project that expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations and Medicaid and CHIP services under the State Plan.

(235) "Optometric Services" means services provided within the scope of practice of optometrists as defined under state law.

(236) "Optometrist" means an individual licensed to practice optometry pursuant to state law.

(237) "Oregon Health Authority (Authority)" means the agency established in ORS chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the Oregon Health Authority are the Public Health Division, Health Systems Division, External Relations, Health Policy and Analytics, Fiscal and Operations, Health System Division, Office of Equity and Inclusion, and the Oregon State Hospital.

(238) "Oregon Youth Authority (OYA)" means the state department charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth corrections.

(239) "Out-of-State Providers" means any provider located outside the borders of the State of Oregon:

(a) Contiguous area providers are those located no more than 75 miles from the border of the State of Oregon;

(b) Non-contiguous area providers are those located more than 75 miles from the borders of the State of Oregon.

(240) "Outpatient Hospital Services" means services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division's Hospital Services administrative rules chapter 410, division 125.

(241) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received.

(242) "Overpayment" means a payment made by the Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.

(243) "Overuse" means use of medical goods or services at levels determined by Authority medical staff or medical consultants to be medically unnecessary or potentially harmful.

(244) "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity. A person with an ownership or control interest is a person or corporation that:

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

(245) "Pantry Stocking Benefit" means a service that allows an HRSN Pantry Stocking Authorized member to purchase or receive from an HRSN Service Vendor or HRSN Service Provider an assortment of foods aimed at promoting improved nutrition for that member. Foods available through this service may be fresh, frozen, dried, pureed, or canned and may include herbs.

(246) "Pantry Stocking Benefit Card" means a service that allows an HRSN Pantry Stocking Authorized member to purchase the Pantry Stocking Benefit from participating food retailers, vendors, or farms, or any combination of them, while utilizing an approved Pantry Stocking Benefit retail card obtained from a vendor that is enrolled with OHA as an HRSN Service Provider.

(247) "Pantry Stocking Grocery Box" means one of the Pantry Stocking Benefits that consists of pre-selected, pre-packaged assortment of foods aimed at promoting improved nutrition that the HRSN Pantry Stocking Authorized Member obtains from an HRSN Pantry Stocking Service Vendor or HRSN Service Provider. Depending on which HRSN Pantry Stocking Service Vendor or HRSN Service Provider, a CCO or the Authority works with, the HRSN Pantry Stocking Authorized Member may have the Pantry Stocking Box delivered to them by the HRSN Pantry

Stocking Vendor or, if available, the Member may be able to pick up the box from the HRSN Pantry Stocking Service Vendor or HRSN Service Provider.¶¶

(2458) "Participating provider" means a provider that has a contractual relationship with an MCE. A Participating Provider is not a Subcontractor solely by virtue of a Participating Provider agreement with an MCE. "Network Provider" has the same meaning as Participating Provider.¶¶

(2469) "Payable Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims directly to the Authority for payment.¶¶

(24750) "Payment Authorization" means authorization granted by the responsible agency, office, or organization for payment prior or subsequent to the delivery of services, as described in these general rules and the appropriate program rules. See the individual program rules for services requiring authorization.¶¶

(24851) "Peer Review Organization (PRO)" means an entity of health care practitioners of services contracted by the state to review services ordered or furnished by other practitioners in the same professional field.¶¶

(24952) "Peer Support Specialist" means an individual providing services to another individual who shares a similar life experience such as (i) addiction to addiction, (ii) mental health condition to mental health condition, or (iii) family member of an individual with a mental health condition to family member of an individual with a mental health condition. A peer support specialist shall be a self-identified individual:¶¶

(a) Currently or formerly receiving addictions or mental health services;¶¶

(b) In recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;¶¶

(c) In recovery from problem gambling.¶¶

(2503) "Peer Wellness Specialist" including Family Support Specialist and Youth Support Specialist means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services, and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.¶¶

(2514) "Person Centered Care" means care that reflects the individual patient's strengths and preferences, reflects the clinical needs of the patient as identified through an individualized assessment, is based upon the patient's goals, and shall assist the patient in achieving the goals.¶¶

(2525) "Personal Health Navigator" means an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions in the patient's particular circumstances and considering the patient's needs, lifestyle, combination of conditions, and desired outcome.¶¶

(2536) "Pharmaceutical Services" means services provided by a pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within the scope of practice.¶¶

(2547) "Pharmacist" means an individual licensed to practice pharmacy pursuant to state law.¶¶

(2558) "Physical Capacity Evaluation" means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the individual.¶¶

(2569) "Physical Therapist" means an individual licensed by the relevant state licensing authority to practice physical therapy.¶¶

(25760) "Physical Therapy" means treatment comprising exercise, massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis, or treatment of a human being. Physical therapy may not include radiology or electrosurgery.¶¶

(25861) "Physician" means an individual licensed to practice medicine pursuant to state law of the state in which they practice medicine or an individual licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or ORS 685.¶¶

(25962) "Physician Associate" means an individual licensed as a physician associate in accordance with ORS 677. Physician associates provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.¶¶

(2603) "Physician Services" means services provided within the scope of practice as defined under state law by or under the personal supervision of a physician.¶¶

(2614) "Podiatric Services" means services provided within the scope of practice of podiatrists as defined under state law.¶¶

(2625) "Podiatrist" means an individual licensed to practice podiatric medicine pursuant to state law.¶¶

(2636) "Post-Payment Review" means review of billings or other medical information for accuracy, medical appropriateness, level of service, or for other reasons subsequent to payment of the claim.¶¶

(2647) "Practitioner" or "Practitioner of the Healing Arts" means an individual licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification.¶¶

(2658) "Prepaid Health Plan (PHP)" means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).¶

(2669) "Presumed HRSN Eligible" means an OHP Member who, through Self-Attestation or other information available to the HRSN Service Provider or, as applicable, the Authority or the MCE, is believed to (i) belong to at least one HRSN Covered Population, (ii) have an HRSN Clinical Risk Factor, and (iii) have an HRSN Social Risk Factor. If the Member provides the HRSN Service Provider with Self-Attestation, the Self-Attestation does not need to identify the Member's specific HRSN Covered Population or their specific HRSN Clinical Risk Factors. For purposes of making a presumption of HRSN Eligibility, it is sufficient that the Member attest that they belong to at least one of the HRSN Covered Populations and have at least one qualifying Clinical Risk Factor. However, the Member must attest to the specific HRSN Service need.¶

(2670) "Primary Care Dentist (PCD)" means a dental practitioner responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.¶

(2687) "Primary Care Provider (PCP)" means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.¶

(2697) "Prior Authorization (PA)" means payment authorization for specified medical services or items given by Authority staff or its contracted agencies before providing the service. A physician referral is not a PA.¶

~~(270) "Prioritized List of Health Services" means the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.¶~~

(2713) "Private Duty Nursing Services" means nursing services provided within the scope of license by a registered nurse or a licensed practical nurse under the general direction of the patient's physician to an individual who is not in a health care facility.¶

(2724) "Provider" means an individual, facility, institution, corporate entity, or other organization enrolled or not enrolled that provides or supplies health services or items, also termed a rendering provider or participating provider, or bills, obligates, and receives reimbursement on behalf of a rendering provider of services, also termed a Billing Provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified.¶

(2735) "Provider Organization" means a group practice, facility, or organization that is:¶

(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or¶

(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or¶

(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and¶

(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility, or organization;¶

(e) An agent if such entity solely submits billings on behalf of providers and payments are made to each provider. (See Subparts of Provider Organization.)¶

(2746) "Psychiatric Emergency Services (PES)" means medical and behavioral health services provided to individuals experiencing an acute disturbance of thought, mood, behavior, or social relationship that requires an immediate intervention as defined by the patient, family, or the community to prevent harm to the patient or others.¶

(2757) "Public Health Clinic" means a clinic operated by a county government.¶

(2768) "Public Rates" means the charge for services and items that providers, including hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients.¶

(2779) "Public Safety Power Shutoff" and "PSPS" means the temporary shutdown of electricity for the purpose of protecting communities in high fire-risk areas when experiencing extreme weather events, which could cause the electrical system to spark wildfires. The decision to implement a PSPS is usually made by the utility provider of the affected service area.¶

(2780) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary as defined by the Social Security Act and its amendments.¶

(2798) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible for Division coverage.¶

(2802) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care.¶

(2843) "Quality Improvement Organization (QIO)" means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization.¶

(2824) "Radiological Services" means those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent radiological facility.¶

(2835) "Recipient" means an individual who is currently eligible for medical assistance (also known as a client).¶

(2846) "Recreational Therapy" means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).¶

(2857) "Recoupment" means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments.¶

(2868) "Reduction of Services" means situations in which the agency authorizes an amount, duration or scope of a service which is less than that requested by the beneficiary or provider. For example, if the individual has requested twenty (20) physical therapy visits and the Division denies the individual's coverage of twenty (20) visits, covering instead only ten (10) visits-this is considered a denial of a service and could be appealed.¶

(2879) "Reentry FCAA Services" means the defined set of existing Medicaid and CHIP services that must be provided to Members who are FCAA-Covered Youth, as defined in OAR 410-155-0000 and 410-155-0010. Reentry FCAA Services include:¶

- (a) Screening and diagnostic services in the thirty (30) days prior to release, or no later than one week, or as soon as practicable, after release; and¶
- (b) Targeted Case Management in the thirty (30) days prior to release and for at least thirty (30) days post-release (as defined in OAR 410-138-0000).¶

(2890) "Referral" means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority.¶

(2891) "Remittance Advice (RA)" means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.¶

(2902) "Rendering provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a provider, or bills, obligates, and receives reimbursement on behalf of a provider of services, also termed a billing provider (BP). The term rendering provider refers to both providers and BP unless otherwise specified.¶

(2943) "Request for Hearing" means a clear expression in writing by an individual or representative that the individual wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.¶

(2924) "Representative" means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.¶

(2935) "Retroactive Medical Eligibility" means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.¶

(2946) "Ride" means non-emergent medical transportation services for a client either to or from a location where covered services are provided. "Ride" does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance.¶

(2957) "Rural" means a geographic area that is ten or more map miles from a population center of 30,000 people or less.¶

(2968) "Sanction" means an action against providers taken by the Authority in cases of misuse or abuse of Oregon Health Authority requirements or fraud, waste and abuse, in accordance with OAR 410-120-1400.¶

(2979) "School Based Health Service" means a health service required by an Individualized Education Plan (IEP) during a child's education program that addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.¶

(298300) "Self-Sufficiency" means the division in the Department of Human Services that administers programs for adults and families. (299) "Service Agreement" means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.¶

(299301) "Service Authorization Request" means a member's initial or continuing request for the provision of a service including member requests made by their provider or the member's authorized representative.¶

(3002) "Service location" means the location of a provider when services are rendered.¶

(3043) "Sliding Fee Schedule" means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.¶

(3024) "Social Worker" means an individual licensed by the Board of Clinical Social Workers to practice clinical social work.¶

(3035) "Special Health Care Needs (SHCN)" means individuals of any age who experience or exhibit signs of developing;¶

(a) Physical, functional, intellectual or developmental disabilities; or¶

(b) Long-standing or chronic medical condition(s); or¶

(c) Complex behavioral health conditions, including "Substance Use Disorders" or "Serious and Persistent Mental Illness;" or¶

(d) Live with other health or social conditions placing them at risk, that without intervention will likely cause negative impact to an individual's health or wellbeing.¶

(3046) "Speech-Language Pathologist" means an individual licensed by the Oregon Board of Examiners for Speech Pathology.¶

(3057) "Speech-Language Pathology Services" means the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.¶

(3068) "State Facility" means a hospital or training center operated by the State of Oregon that provides long-term medical or psychiatric care.¶

(3079) "Supplemental Health Benefit State Funding" means funding for the health benefits included in the Healthier Oregon benefits package described in OAR 410-134-0004(3)(a-m).¶

(3108) "Subparts (of a Provider Organization)" means for NPI application, subparts of a health care provider organization may meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically or has an entity do so on its behalf and could be components of an organization or separate physical locations of an organization.¶

(30911) "Subrogation" means right of the state to stand in place of the client in the collection of Third-Party Resources (TPR).¶

(3102) "Substance Use Disorder (SUD) Services" means assessment, treatment, and rehabilitation on a regularly scheduled basis or in response to crisis for alcohol or other drug abuse for dependent members and their family members or significant others, consistent with Level I, Level II, or Level III of the most currently published edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC). SUD is an interchangeable term with Chemical Dependency (CD), Alcohol and other Drug (AOD), and Alcohol and Drug (A & D).¶

(3143) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled persons that is administered by the Social Security Administration through the Social Security office.¶

(3124) "Surgical Assistant" means an individual performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.¶

(3135) "Suspension" means a temporary sanction prohibiting a provider's participation in the medical assistance programs by suspending the provider's Authority-assigned provider number for a specified period of time for one or more of the reasons in OAR 410-120-1400. No payments, Title XIX, or State Funds shall be made for services provided while the provider is suspended.¶

(3146) "Targeted Case Management (TCM)" means activities that assist the client in a target group in gaining access to needed medical, social, educational, and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by allied agency providers.¶

(3157) "Telecommunication technologies" means the use of devices and services for telemedicine or telehealth delivered services. These technologies include videoconferencing, store-and-forward imaging, streaming media including services with information transmitted via landlines, and wireless communications, including the Internet and telephone networks.¶

(3168) "Telehealth" includes telemedicine and includes the use of electronic information and telecommunications technologies to support remote clinical healthcare, client or member and professional health-related education, public health, and health administration.¶

(3179) "Telemedicine" means the mode of delivering remote clinical health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a client or member's healthcare.¶

(31820) "Termination" means a sanction prohibiting a provider's participation in the Authority's programs by canceling the provider's Authority-assigned provider number and provider agreement for one or more of the reasons in OAR 410-120-1400 and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. No payments, Title XIX, or state funds shall be made for services provided after the date of

termination. Termination is permanent unless:¶¶

(a) The exceptions to mandatory exclusion are met; or¶¶

(b) Otherwise stated by the Authority at the time of termination.¶¶

~~(3219)~~ "Third Party Liability (TPL), Third Party Resource (TPR), or Third party payer" means a medical or financial resource that, under law, is available and applicable to pay for medical services and items for an Authority client.¶¶

~~(3202)~~ "Traditional Health Worker" means a community health worker, peer wellness specialist, personal health navigator, peer support specialist, birth doula, or other similar health workers not regulated or certified by the State of Oregon.¶¶

~~(3243)~~ "Transportation" means medical transportation.¶¶

~~(3224)~~ "Trauma informed approach" means approach undertaken by providers and healthcare or human services programs, organizations, or systems in providing mental health and substance use disorders treatment where there is a recognition and understanding of the signs and symptoms of trauma in, and the intensity of such trauma on, individuals, families, and others involved within a program, organization, or system, and then takes into account those signs, symptoms, and their intensity and fully integrates that knowledge when implementing and providing potential paths for recovery from mental health or substance use disorders. The Trauma Informed Approach also means that providers and healthcare or human services programs, organizations, or systems actively resist re-traumatization of the individuals being served within their respective entities.¶¶

~~(3235)~~ "Trauma Informed Services" means those services provided using a trauma informed approach.¶¶

~~(3246)~~ "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.¶¶

~~(3257)~~ "Type B AAA" means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services, and regulatory programs for the elderly or the elderly and disabled.¶¶

~~(3268)~~ "Type B AAA Unit" means a Type B AAA funded by Oregon Project Independence (OPI), Title III-Older Americans Act, and Title XIX of the Social Security Act.¶¶

~~(3279)~~ "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.¶¶

~~(32830)~~ "Urban" means a geographic area that is less than ten map miles from a population center of 30,000 people or more.¶¶

~~(32931)~~ "Urgent Care Services" means health services that are medically appropriate and immediately required to prevent serious deterioration of a client's health that are a result of unforeseen illness or injury.¶¶

~~(3302)~~ "Usual Charge (UC)" means the lesser of the following unless prohibited from billing by federal statute or regulation:¶¶

(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;¶¶

(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted, or posted. The lesser of these applies regardless of the payment source or means of payment;¶¶

(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200 percent of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to Third Party Resources (TPR) are to be considered.¶¶

~~(3334)~~ "Utilization Review (UR)" means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.¶¶

~~(3324)~~ "Valid Claim" means an invoice received by the Division or the appropriate Authority or Department office for payment of covered health care services rendered to an eligible client that:¶¶

(a) Can be processed without obtaining additional information from the provider of the goods or services or from a TPR; and¶¶

(b) Has been received within the time limitations prescribed in these General Rules (OAR chapter 410 division 120).¶¶

~~(3335)~~ "Valid Preauthorization" means a document the Authority, a PHP, or CCO receives requesting a health service for a member who may be eligible for the service at the time of the service, and the document contains:¶¶

(a) A beginning and ending date not exceeding twelve months, except for cases of PHP or CCO enrollment where four months may apply; and¶¶

(b) All data fields required for processing the request or payment of the service including the appropriate billing codes.¶¶

~~(3346)~~ "Very Low Food Security" means reports of multiple indications of disrupted eating patterns and reduced food intake, as measured by the U.S. Household Food Security Survey Module: Six Item Short Form from the U.S. Department of Agriculture published in May 2024, available here:

https://www.ers.usda.gov/sites/default/files/_laserfiche/DataFiles/50764/short2024.pdf¶¶

~~(3357)~~ "Vision Services" means provision of corrective eyewear, including ophthalmological or optometric

examinations for determination of visual acuity and vision therapy and devices.¶¶

~~(3368)~~ "Volunteer" (for the purposes of NEMT) means an individual selected, trained and under the supervision of the Department who is providing services on behalf of the Department in a non-paid capacity except for incidental expense reimbursement under the Department Volunteer Program authorized by ORS 409.360.¶¶

~~(3372)~~ "Young Adults with Special Health Care Needs (YSHCN)" means a program that provides young adults who meet pre-determined social and clinical criteria with supplementary benefits, in addition to OHP Plus or Healthier Oregon coverage. The supplementary benefits include EPSDT services, HRSN services, and extended vision and dental services. The YSHCN program is more fully described in OAR 410-200-0455.

Statutory/Other Authority: ORS 413.042, ORS 414.065, 414.231

Statutes/Other Implemented: ORS 414.025, ORS 414.065

RULE SUMMARY: Remove reference to a funding line on the Prioritized List.

Revise definition of the Prioritized List of Health Services, including addition of definition for the OHA Prioritized List.

Add definition of Letter of Medical Necessity.

CHANGES TO RULE:

410-120-0025

Administration of Division of Medical Assistance Programs, Regulation and Rule Precedence ¶

(1) The Oregon Health Authority (Authority) and its Division of Medical Assistance Programs (Division) may adopt reasonable and lawful policies, procedures, rules, and interpretations to promote the orderly and efficient administration of medical assistance programs including the Oregon Health Plan pursuant to ORS 414.065 (generally, fee-for-service), 414.591 (Coordinated Care Organizations), and 414.115 to 414.145 (services contracts), subject to the rulemaking requirements of the Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.¶

(2) In applying its policies, procedures, rules, and interpretations, the Division shall construe them as much as possible to be complementary. In the event that Division policies, procedures, rules and interpretations may not be complementary, the Division shall apply the following order of precedence to guide its interpretation:¶

(a) For purposes of the provision of covered medical assistance to Division clients, including but not limited to authorization and delivery of service or denials of authorization or services, the Division, clients, enrolled providers, Coordinated Care Organizations, and the Prepaid Health Plans shall apply the following order of precedence:¶

(A) Oregon Revised Statutes governing medical assistance programs;¶

(B) Consistent with ORS 413.071, those federal laws and regulations governing the operation of the medical assistance program and any waivers granted the Authority by the Centers for Medicare and Medicaid Services to operate medical assistance programs including the Oregon Health Plan;¶

(C) Generally for Coordinated Care Organizations, the requirements applicable to the providing covered medical assistance to Division clients are found in OAR 410-141-3500 through 410-141-5380; and where applicable, 410-120-0000 through 410-120-1990; and the provider rules applicable to the category of medical service;¶

(D) Generally for Prepaid Health Plans, the requirements applicable to providing covered medical assistance to Division clients are found in OAR 410-141-3500 through 410-141-5380; and where applicable, 410-120-0000 through 410-120-1990; and the provider rules applicable to the category of medical service;¶

(E) Generally for enrolled fee-for-service providers or other contractors, the requirements applicable to providing covered medical assistance to Division clients are found in OAR 410-120-0000 through 410-120-1990, the OHA Prioritized List and program coverage set forth in 410-141-3820 to 410-141-3830, and the provider rules applicable to the category of medical service;¶

(F) Any other applicable duly promulgated rules issued by the Division and other offices or units within the Authority or Department of Human Services necessary to administer the State of Oregon's medical assistance programs, such as electronic data transaction rules in OAR 943-120-0100 to 943-120-0200; and¶

(G) The basic framework for provider enrollment in OAR 943-120-0300 through 943-120-0380 that generally apply to providers enrolled with the Authority or Department, subject to more specific requirements applicable to the administration of the Oregon Health Plan and medical assistance programs administered by the Authority. For purposes of this rule, "more specific" means the requirements, laws and rules applicable to the provider type and covered services described in paragraphs (A)-(F) of this section of this rule.¶

(b) For purposes of contract administration solely as between the Authority and its Coordinated Care Organizations or Prepaid Health Plans, the terms of the applicable contract and the requirements in section (2)(a) of this rule apply to the provision of covered medical assistance to Division clients:¶

(A) Nothing in this rule shall be deemed to incorporate into contracts provisions of law not expressly incorporated into such contracts, nor shall this rule be deemed to supersede any rules of construction of such contracts that may be provided for in such contracts;¶

(B) Nothing in this rule gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly or indirectly or otherwise, to any individual or entity unless the individual or entity is identified as a named party to the contract.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Update reference to the OHA Prioritized List, and to OAR 410-141-3830. Replace references to a "client" with "Member." Capitalize defined terms.

CHANGES TO RULE:

410-120-1160

Medical Assistance Benefits and Provider Rules ¶

(1) Providers enrolled with and seeking reimbursement for services through the ~~Health Systems Division~~ ~~(Division)~~ Division are responsible for compliance with current federal and state laws and regulations governing Medicaid services and reimbursement, including familiarity with periodic law and rule changes. The Division's administrative rules are posted on the Oregon Health Authority (Authority) website for the Division and its ~~m~~Medical ~~a~~Assistance ~~p~~Programs. It is the ~~p~~Provider's responsibility to become familiar with and abide by these rules. ¶

(2) The following services are covered to the extent included in the ~~Division client~~ Member's bBenefit ~~p~~Package of health care services, when ~~m~~Medically or ~~d~~Dentally ~~a~~Appropriate and within the limitations established by the Division and set forth in the Oregon Administrative Rules (OARs) for each category of ~~H~~health ~~S~~services: ¶

(a) Acupuncture services as described in the Medical-Surgical Services program provider rules (OAR chapter 410, division 130); ¶

(b) Administrative examinations as described in the Administrative Examinations and Billing Services program provider rules (OAR chapter 410, division 150); ¶

(c) Substance Use Disorder ~~treatment s~~Services: ¶

(A) The Division covers Substance Use Disorder (SUD) inpatient treatment services for medically managed intensive inpatient detoxification when provided in an ~~a~~Acute care ~~h~~Hospital and when hospitalization is considered ~~m~~Medically ~~a~~Appropriate. The Division covers medically monitored detoxification and clinically managed detoxification provided in a free standing detoxification center or an appropriately licensed SUDs residential treatment facility when considered ~~m~~Medically ~~a~~Appropriate; ¶

(B) The Division covers non-hospital SUD treatment and recovery services on a residential or outpatient basis. For information to access these services, contact the ~~client's PHP or~~ Member's CCO if enrolled, the Community Mental Health Program (CMHP), an outpatient substance use disorder treatment ~~p~~Provider, the residential treatment program, or the ~~Addictions and Mental~~ Behavioral Health Division (AMHBHD); ¶

(C) The Division does not cover residential level of care provided in an inpatient ~~h~~Hospital setting for ~~s~~Substance ~~u~~Use ~~d~~Disorder ~~treatment and recovery s~~Services: ¶

(d) Ambulatory ~~s~~Surgical ~~c~~Center (ASC) services as described in the Medical-Surgical Services program ~~p~~Provider rules (OAR 410, division 130); ¶

(e) Anesthesia services as described in the Medical-Surgical Services program ~~provider~~ rules (OAR chapter 410, division 130); ¶

(f) Audiology services as described in the Speech-Language Pathology, Audiology and Hearing Aid Services program ~~p~~Provider rules (OAR chapter 410, division 129); ¶

(g) Chiropractic services as described in the Medical-Surgical Services program ~~provider~~ rules (OAR chapter 410, division 130); ¶

(h) Clinical trials ~~as described in these General Rules~~: ¶

(A) Coverage includes routine patient costs for a beneficiary participating in a qualifying clinical trial or any item or service provided to the individual under the qualifying clinical trial, including any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the items or services to the beneficiary are covered in the ~~recipient~~ Member's bBenefit ~~p~~Package; ¶

(B) "Qualifying clinical trial" is defined as a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition as described in section 1905(gg)(2)(A) of the Act; ¶

(C) A qualifying clinical trial is a study or investigation that is approved, conducted, or supported (including by funding through in-kind contributions) by one or more of the following: ¶

(i) The National Institutes of Health (NIH); ¶

(ii) The Centers for Disease Control and Prevention (CDC); ¶

(iii) The Agency for Health Care Research and Quality (AHRQ); ¶

(iv) The Centers for Medicare & Medicaid Services (CMS); ¶

(v) A cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs; ¶

- (vi) A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants;¶
- (vii) A clinical trial, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review that the Secretary determines comparable to the system of peer review of studies and investigations used by the NIH, and that assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review;¶
- (I) The Department of Energy;¶
- (II) The Department of Veterans Affairs;¶
- (III) The Department of Defense;¶
- (viii) A clinical trial that is one conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act; or¶
- (ix) A clinical trial that is a drug trial exempt from being required to have one of the exemptions in the prior ~~bullet~~ ~~subparagraph~~.¶
- (D) Items and ~~S~~services not included in clinical trial;¶
- (i) Routine patient costs do not include any investigational item or service that is the subject of the qualifying clinical trial but is not included in the ~~recipient's OHP~~ ~~Member's Benefit~~ ~~p~~Package;¶
- (ii) Routine patient cost does not include any item or service that is provided to the beneficiary solely to satisfy data collection and analysis for the qualifying clinical trial that is not used in the direct clinical management of the beneficiary and is not otherwise in the ~~recipients OHP~~ ~~Member's Benefit~~ ~~p~~Package.¶
- (i) Dental services as described in the Dental Services program ~~provider~~ rules (OAR chapter 410, division 123);¶
- (j) Early and Periodic Screening, Diagnosis, and Treatment services (EPSDT) are covered for individuals under 21 years of age as set forth in the individual program ~~provider~~ rules. The Division may authorize services in excess of limitations established in the OARs when it is ~~m~~Medically ~~a~~Appropriate to treat a condition that is identified as the result of an EPSDT screening;¶
- (k) Family ~~p~~Planning ~~s~~Services as described in the Medical-Surgical Services program ~~provider~~ rules (OAR chapter 410, division 130);¶
- (l) Federally ~~q~~Qualified ~~h~~Health ~~c~~Centers (FOHC) and ~~r~~Rural ~~h~~Health ~~c~~Clinics (RHC) as described in the Federally Qualified Health Centers and Rural Health Clinics program ~~provider~~ rules (OAR chapter 410, division 147);¶
- (m) Home and community-based waiver services as described in the Authority and the Department's OARs of Child Welfare (CW), Self-Sufficiency Program (SSP), ~~Addictions and Mental~~Behavioral Health Division (AMHBHD), and Aging and People with Disabilities Division (APD);¶
- (n) Home enteral/parenteral nutrition and IV services as described in the Home Enteral/Parenteral Nutrition and IV Services program rules (OAR chapter 410, division 148) and related Durable Medical Equipment, Prosthetics, Orthotics and Supplies program rules (OAR chapter 410, division 122) and Pharmaceutical Services program rules (OAR chapter 410, division 121);¶
- (o) Home ~~h~~Health ~~s~~Services as described in the Home Health Services program rules (OAR chapter 410, division 127);¶
- (p) Hospice services as described in the Hospice Services program rules (OAR chapter 410, division 142);¶
- (q) HRSN Services as described in the HRSN Services program rules (OAR 410-120-2000);¶
- (r) Indian ~~h~~Health ~~s~~Services or tribal facility as described in ~~T~~the Indian Health Care Improvement Act and its amendments (Public Law 102-573), and the Division's American Indian/Alaska Native program rules (OAR chapter 410, division 146);¶
- (s) Inpatient ~~h~~Hospital ~~s~~Services as described in the Hospital Services program rules (OAR chapter 410, division 125);¶
- (t) Laboratory ~~s~~Services as described in the Hospital Services program rules (OAR chapter 410, division 125) and the Medical-Surgical Services program rules (OAR chapter 410, division 130);¶
- (u) Licensed ~~d~~Direct-~~e~~Entry ~~m~~Midwife services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);¶
- (v) Maternity ~~c~~Case ~~m~~Management as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);¶
- (w) Medical equipment and supplies as described in the Hospital Services program, Medical-Surgical Services program, DMEPOS program, Home Health Services program, Home Enteral/Parenteral Nutrition and IV Services program, and other rules;¶
- (x) When a ~~client~~Member's ~~b~~Benefit ~~p~~Package includes mental health, the mental health services provided shall be based on the ~~Health Evidence Review Commission (HERC)~~OHA Prioritized List of Health Services;¶
- (y) Naturopathic ~~s~~Services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);¶
- (z) Nutritional ~~c~~Counseling as described in the Medical-Surgical Services program rules (OAR chapter 410, division

130);.¶

(aa) Occupational ~~E~~Therapy as described in the Physical and Occupational Therapy Services program rules (OAR chapter 410, division 131);.¶

(bb) Organ transplant services as described in the Transplant Services program rules (OAR chapter 410, division 124);.¶

(cc) Outpatient ~~H~~Hospital ~~S~~Services including clinic services, ~~E~~Emergency ~~d~~Department services, ~~P~~Physical and ~~O~~Occupational ~~E~~Therapy services, and any other ~~O~~Outpatient ~~H~~Hospital ~~S~~Services provided by and in a ~~H~~Hospital as described in the Hospital Services program rules (OAR chapter 410, division 125);.¶

(dd) Physician, ~~P~~Podiatrist, ~~N~~Nurse ~~P~~Practitioner and licensed physician associate-/services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130);.¶

(ee) Physical ~~E~~Therapy as described in the Physical and Occupational Therapy and the Hospital Services program rules (OAR chapter 410, division 131 and 125);.¶

(ff) Post-hospital extended care benefit as described in OAR chapter 410, division 120, 141 and OAR chapter 411, division 070, Aging and People with Disabilities (APD) program rules;.¶

(gg) Prescription drugs including home enteral and parenteral nutritional services and home intravenous services as described in the Pharmaceutical Services program (OAR chapter 410, division 121), the Home Enteral/Parenteral Nutrition and IV Services program (OAR chapter 410, division 148), and the Hospital Services program rules (OAR chapter 410, division 125);.¶

(hh) Preventive services as described in the Medical-Surgical Services program (OAR chapter 410, division 130), the Dental Services program rules (OAR chapter 410, division 123), and prevention guidelines associated with the ~~Health Evidence Review Commission's~~OHA Prioritized List of Health Services (OAR 410-141-0523830);.¶

(ii) Private duty nursing as described in the Private Duty Nursing Services program rules (OAR chapter 410, division 132);.¶

(jj) Private Duty Nursing Services as described in the Private Duty Nursing Services program rules (OAR chapter 410, division 132);.¶

(kk) Radiology and imaging services as described in the Medical-Surgical Services program rules (OAR chapter 410, division 130), the Hospital Services program rules (OAR chapter 410, division 125), and Dental Services program rules (OAR chapter 410, division 123);.¶

(~~kk~~ll) Rural health clinic services as described in the Federally Qualified Health Center and Rural Health Clinic Program rules (OAR chapter 410, division 147);.¶

(~~mm~~) School-~~B~~Based ~~H~~Health ~~S~~Services as described in the School-Based Health Services Program rules (OAR chapter 410, division 133);.¶

(~~mmnn~~) Speech and language therapy as described in the Speech-Language Pathology, Audiology and Hearing Aid Services program rules (OAR chapter 410, division 129) and Hospital Services program rules (OAR chapter 410, division 125);.¶

(~~nnoo~~) Transportation necessary to access a covered medical service or item as described in the Medical Transportation program rules (OAR chapter 410, division 136);.¶

(~~oo~~pp) Vision ~~S~~Services as described in the Visual Services program rules (OAR chapter 410, division 140).¶

(3) Other Authority or Department, divisions, units, or offices, including Vocational Rehabilitation, ~~AMHBHD~~, and APD may offer services to Medicaid eligible ~~client~~Members, that are not reimbursed by or available through the Division of Medical Assistance Programs;.¶

[Publications: Publications referenced are available from the agency.]

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065, SB 269-b (2025)

RULE SUMMARY: Update reference to the OHA Prioritized List and to the State Plan.

CHANGES TO RULE:

410-120-1200

Excluded Services and Limitations ¶¶

(1) Certain services or items are not covered under any program or for any group of eligible clients. Service limitations are subject to either: ¶¶

(a) the ~~Health Evidence Review Commission (HERC)~~ OHA Prioritized List of Health Services as referenced in Oregon Administrative Rule (OAR) 410-141-3830 and the individual program chapter 410 OARs; or ¶¶

(b) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as set forth in chapter 410 Division 151. ¶¶

(2) If the client accepts financial responsibility for a non-covered service, payment is a matter between the provider and the client subject to the requirements of OAR 410-120-1280. ¶¶

(3) The Health Systems Division (Division) shall make no payment for any expense incurred for services or items that meet any of the following: ¶¶

(a) Determined not medically or dentally appropriate by Division staff or authorized representatives, including the Division's contracted utilization review organization, or are not covered ~~by the Health Evidence Review Commission Prioritized List of Health Services;~~ under the State Plan; ¶¶

(b) Not properly prescribed as required by law or administrative rule by a licensed practitioner practicing within their scope of practice or licensure; ¶¶

(c) For routine checkups or examinations for individuals age 21 or older in connection with participation, enrollment, or attendance in an extracurricular program or activity not related to the improvement of health and rehabilitation of the client. Examples include routine drug test used for employment or exams for employment, or life insurance exams; (3)(c) of this rule is not for vaccines, for vaccine eligible coverage see OAR 410-130-0255. ¶¶

(d) Provided by friends or relatives of eligible clients or members of his or her household, except when the friend, relative or household member: ¶¶

(A) Is a health professional acting in a professional capacity; or ¶¶

(B) Is directly employed by the client under the Department of Human Services (Department) Aging and People with Disabilities division (APD) Home and Community Based Services or the APD administrative rules, OAR 411-034-0000 through 411-034-0090, governing Personal Care Services covered by the State Plan; or ¶¶

(C) Is directly employed by the client under the Department Child Welfare administrative rules, OAR 413-090-0100 through 413-090-0220, for services to children in the care and custody of the Department who have special needs inconsistent with their ages. A family member of a minor client (under the age of 18) must not be legally responsible for the client in order to be a provider of personal care services; ¶¶

(e) For services or items provided to a client who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, except such services as designated by federal statute or regulation as permissible for coverage under the Division's administrative rules (i.e., inpatient hospitalizations); ¶¶

(f) Needed for purchase, repair, or replacement of materials or equipment caused by adverse actions of adult clients age 21 and over to personally owned goods or equipment or to items or equipment that the Division rented or purchased; ¶¶

(g) Related to a non-covered service, some exceptions are identified in the individual provider rules. If the Division determines the provision of a service related to a non-covered service is cost effective, the related medical service may, at the discretion of the Division and with Division prior authorization (PA), be covered; ¶¶

(h) Considered experimental or investigational, that deviates from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy; ¶¶

(i) Identified in the appropriate program rules including the Division's Hospital Services program administrative rules, Revenue Codes Section, as non-covered services; ¶¶

(j) Requested by or for a client whom the Division has determined to be non-compliant with treatment and who is unlikely to benefit from additional related, identical, or similar services; ¶¶

(k) For copying or preparing records or documents, except those Administrative Medical Reports requested by the branch offices or the Division for casework planning or eligibility determinations; ¶¶

~~(L)~~ Whose primary intent is to improve appearances, exceptions subject to the ~~HERC~~ OHA Prioritized List coverage and guidelines; ¶¶

(m) Similar or identical to services or items that shall achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client shall be essentially the same; ¶¶

- (n) For the purpose of establishing or reestablishing fertility or pregnancy;¶
 - (o) Items or services that are for the convenience of the client and are not medically or dentally appropriate;¶
 - (p) The collection, processing, and storage of autologous blood or blood from selected donors unless a physician certifies that the use of autologous blood or blood from a selected donor is medically appropriate and surgery is scheduled;¶
 - (q) Educational or training classes that are not intended to improve a medical condition;¶
 - (r) Outpatient social services except maternity case management services and other social services described as covered in the individual provider rules;¶
 - (s) Post-mortem exams or burial costs;¶
 - (t) Radial keratotomies;¶
 - (u) Recreational therapy;¶
 - (v) Telephone calls except for:¶
 - (A) Tobacco cessation counseling as described in OAR 410-130-0190;¶
 - (B) Maternity case management as described in OAR 410-130-0595;¶
 - (C) Telemedicine as described in OAR 410-120-1990; and¶
 - (D) Services specifically identified as allowable for telephonic delivery when appropriate in the mental health and substance use disorder procedure code and reimbursement rates published by the Addiction and Mental Health division.¶
 - (w) Services that have no standard code set as established according to 45 CFR 162.1000 to 162.1011, unless the Division has assigned a procedure code to a service authorized in rule;¶
 - (x) Whole blood (Whole blood is available at no cost from the Red Cross). The processing, storage, and costs of administering whole blood are covered;¶
 - (y) Services that are requested or ordered but not provided to the client, unless specified otherwise in individual program rules;¶
 - (z) Missed appointments, an appointment that the client fails to keep. Refer to OAR 410-120-1280;¶
 - (aa) Transportation to meet a client's personal choice of a provider;¶
 - (bb) Alcoholics Anonymous (AA) and other self-help programs;¶
 - (cc) Medicare Part D covered prescription drugs or classes of drugs and any cost sharing for those drugs for Medicare-Medicaid Fully Dual Eligible clients, even if the Fully Dual Eligible client is not enrolled in a Medicare Part D plan. See OAR 410-120-1210 for benefit package;
- Statutory/Other Authority: ORS 413.042
 Statutes/Other Implemented: ORS 414.065, ORS 414.025

AMEND: 410-120-1210

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-120-1210

Medical Assistance Benefit Packages and Delivery System ¶

(1) The services clients are eligible to receive are based on their benefit package. Not all packages receive the same benefits. ¶

(2) The Health Systems Division (Division), Medical Assistance Programs benefit package description, codes, eligibility criteria, coverage, limitations, and exclusions are identified in these rules. ¶

(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in any chapter 410 OARs. ¶

(4) Benefit package descriptions: ¶

(a) Oregon Health Plan (OHP) Plus: ¶

(A) Benefit package identifier: BMH; ¶

(B) Eligibility criteria: As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if they are eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria; ¶

(C) Coverage includes: ¶

(i) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage for individuals under age 21 and individuals who qualify for the Young Adults with Special Health Care Needs (YSHCN) program, as detailed in Chapter 410 Division 151. ¶

(ii) Services consistent with the ~~Health Evidence Review Commission (HERC)~~ OHA Prioritized List of Health Services (OHA Prioritized List), (OAR 410-141-3820 through 410-141-3830); ¶

(iii) Ancillary services, (OAR 410-141-3820); ¶

(iv) Substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers; ¶

(v) Mental health services based on the OHA Prioritized List to be provided by Board licensed, certified, or credentialed providers or through Community Mental Health Programs certified and credentialed providers; ¶

(vi) Hospice; ¶

(vii) Post-hospital extended care benefit up to a one hundred (100) day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Coordinated Care Organization (CCO) for clients enrolled in a CCO; and ¶

(viii) HRSN Services (OAR 410-120-2005). ¶

(D) Limitations: ¶ Except for individuals who qualify for the Young Adults with Special Health Care Needs program (see OAR 410-200-0455), the following services have limited coverage for non-pregnant adults age 21 and older, who are outside of the protected postpartum eligibility period (see OAR 410-200-0135). (Refer to the cited OAR chapters and divisions for details): ¶

(i) Selected dental (OAR chapter 410, division 123 and 200); ¶

(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140 and 200). ¶

(b) OHP with Limited Drugs: ¶

(A) Benefit package identifier: BMM, BMD; ¶

(B) Eligibility criteria: Eligible clients are eligible for Medicare and Medicaid benefits; ¶

(C) Coverage includes: services covered by Medicare and OHP Plus as described in this rule; ¶

(D) Limitations: ¶

(i) The same as OHP Plus as described in this rule; ¶

(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to: ¶

(I) Over-the-counter (OTC) drugs; ¶

(II) Barbiturates (except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D shall cover those indications). ¶

(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug; ¶

(F) Payment for services is limited to the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible; ¶

(G) Cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package. ¶

(c) Qualified Medicare Beneficiary (QMB)-Only: ¶

(A) Benefit Package identifier code MED; ¶

(B) Eligibility criteria: Eligible clients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage; ¶

(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid-allowed payment less the Medicare payment up to the amount of co-insurance and deductible but no more than the Medicare allowable; ¶

(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare; ¶

(E) Medicare is the source of benefit coverage for service; therefore, an OHP 3165 is not required for this eligibility group. A Medicare Advance Beneficiary Notice of Noncoverage (ABN) may be required by Medicare, refer to Medicare for ABN requirements. ¶

(d) Citizenship Waived Medical (CWM) Benefit Package defined in OAR 410-120-0000. Refer to OARs 410-134-0005(2) and 410-134-0005(3) for coverage and billing guidance. ¶

(e) Compact of Free Association (COFA) Dental Program: ¶

(A) Benefit Package identifier code DEN; ¶

(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445; ¶

(C) Coverage is state funded and includes the types and extent of Dental services that the Authority determines shall be provided to medical assistance recipients in accordance with OAR chapter 410 division 123. ¶

(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services. ¶

(E) No copayments, deductibles or cost sharing shall be required for eligible clients. ¶

(f) Veteran Dental Program: ¶

(A) Benefit Package identifier code DEN and DNT; ¶

(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0445; ¶

(C) Coverage is state funded and includes the types and extent of dental services that the Authority determines shall be provided to medical assistance recipients in accordance with OAR chapter 410 division 123. ¶

(D) Coverage also includes pharmaceuticals prescribed by a dental health care provider as component of covered dental services. ¶

(E) No copayments, deductibles or cost sharing shall be required for eligible clients. ¶

(g) Young Adults with Special Health Care Needs (YSHCN) Program: ¶

(A) Benefit package identifier codes BMH, BMM, or BMD; ¶

(B) Eligibility criteria: Eligible clients are specified in OAR 410-200-0455; ¶

(C) Coverage: Eligible individuals receive OHP Plus coverage with the following supplemental benefits: ¶

(i) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage as described in chapter 410 Division 151; ¶

(ii) All dental and vision services available to EPSDT beneficiaries, as detailed in chapter 410 Division 123 and chapter 410 Division 140; and ¶

(iii) Health-Related Social Needs or "HRSN" services (as defined in OAR 140-120-0000 and detailed in OAR 410-120-2000) are available to those receiving YSHCN as an "HRSN Covered Population". ¶

(D) Limitations: Individuals receiving OHP Plus benefits under the YSHCN program are not eligible for long-term care services and supports under Oregon's 1915(c) waiver, and HRSN services must be annually reassessed for eligibility for HRSN services as set out in OAR 410-120-2015. ¶

(5) Division clients are enrolled for covered health services and HRSN Services to be delivered through one of the following means: ¶

(a) Coordinated Care Organization (CCO): ¶

(A) These clients are enrolled in a CCO that provides integrated and coordinated health care; ¶

(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, substance use disorder treatment and recovery, mental health services, dental care, or HRSN Services. ¶

(b) Fee-for-service (FFS): ¶

(A) These clients are not enrolled in a CCO; ¶

(B) Subject to limitations and restrictions in the Division's individual program rules, the client may receive health care from any Division-enrolled provider that accepts FFS clients. The provider shall bill the Division directly for any covered service and shall receive a fee for the service provided. ¶

(C) Delivery of HRSN Services for members enrolled in FFS shall be provided as set forth in OAR 410-120-2000.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042, ORS 414.025, 414.065, 414.329, 414.706, 414.710, 414.432, 414.312, 414.430, 414.690, 414.572, 414.605, 414.665, 414.719, SB 269-b (2025)

AMEND: 410-120-1560

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-120-1560

Provider Appeals ¶¶

(1) For purposes of Division provider appeal rules in chapter 410, division 120, the following terms and definitions are used:¶¶

(a) "Provider" means an individual or entity enrolled with the Division or under contract with the Division that is subject to the Division rules and that has requested an appeal in relation to health care, items, drugs, or services provided or requested to be provided to a client on a fee-for-service basis or under contract with the Division where that contract expressly incorporates these rules;¶¶

(b) "Provider Applicant" means an individual or entity that has submitted an application to become an enrolled provider with the Division, but the application has not been approved;¶¶

(c) "Prepaid Health Plan" has the meaning set forth in OAR 410-141-3500, except to the extent that Mental Health Organizations (MHO) have separate procedures applicable to provider grievances and appeals;¶¶

(d) "Prepaid Health Plan provider" means an individual or entity enrolled with the Division but that provided health care services, supplies or items to a client enrolled with a PHP, including both participating providers and non-participating providers as those terms are defined in OAR 410-141-0000, except that services provided to a client enrolled with an MHO shall be governed by the provider grievance and appeal procedures administered by the Authority's Addictions and Mental Health Division;¶¶

(e) The "Provider Appeal Rules" refers to the rules in OAR 410-120-1560 to 410-120-1600, describing the availability of appeal procedures and the procedures applicable to each;¶¶

(f) "Non-participating provider" has the meaning set forth in OAR 410-141-3500;¶¶

(g) Coordinated Care Organization (CCO) has the meaning set forth in OAR 410-141-3500.¶¶

(2) A Division enrolled provider may appeal a Division decision in which the provider is directly adversely affected including but not limited to the following:¶¶

(a) A denial or limitation of payment allowed for services or items provided;¶¶

(b) A denial related to an NCCI edit;¶¶

(c) A denial of provider's application for new or continued participation in the Medical Assistance Program; or¶¶

(d) Sanctions imposed, or intended to be imposed, by the Division on a provider or provider entity; and¶¶

(e) Division overpayment determinations made under OAR 410-120-1397.¶¶

(3) Client appeals of actions must be handled in accordance with OAR 140-120-1860 and 410-120-1865.¶¶

(4) A provider appeal is initiated by filing a timely request in writing for review with the Division:¶¶

(a) A provider appeal request is not required to follow a specific format as long as it provides a clear written expression from a provider or provider applicant expressing disagreement with a Division decision or from a CCO or PHP provider expressing disagreement with a decision by a CCO or PHP.¶¶

(b) The request must identify the decision made by the Division, a CCO, or PHP that is being appealed and the reason the provider disagrees with that decision.¶¶

(c) A provider appeal request is timely if it is received by the Division:¶¶

(A) Within 180 calendar days from the date of the Division's fee-for-service decision;¶¶

(B) Within 30 calendar days from the date of the CCO or PHP decision after the provider completes the CCO or PHP appeal process.¶¶

(5) Types and methods for provider appeals are:¶¶

(a) Claim redeterminations: A Division denial of or limitation of payment allowed, including prior authorization decision, or Division overpayment determination for services or items provided to a client must be appealed as claim re-determinations under OAR 410-120-1570.¶¶

(b) Contested Case: A notice of sanctions imposed or intended to be imposed, the effect of the notice of sanction is, or will be, to deny, suspend, or revoke a provider number necessary to participate in the medical assistance on a provider, or provider applicant is entitled to appeal under OAR 410-120-1600. A provider that may appeal a notice of sanction as a contested case may choose to request administrative review instead of contested case hearing if the provider submits a written request for administrative review and agrees in writing to waive the right to a contested case hearing and the Division agrees to review the appeal as an administrative review.¶¶

(c) Administrative review: All provider appeals of Division decisions not described in section (5)(a) or (b) of this rule are handled as administrative reviews in accordance with OAR 410-120-1580, unless the Division issues an order granting a contested case hearing.¶¶

- (6) Decisions that adversely affect a provider may be made by different program areas within the Authority;¶
- (a) Decisions issued by the Office of Payment Accuracy and Recovery (OPAR) or the Authority information security office shall be appealed in accordance with the process described in the notice;¶
- (b) Other program areas within the Authority that have responsibility for administering medical assistance funding, such as nursing home care or community mental health and developmental disabilities program services, may make decisions that adversely affect a provider. Those providers are subject to the provider grievance or appeal processes applicable to those payment or program areas;¶
- (c) Some decisions that adversely affect a provider are issued on behalf of the Division by Authority contractors such as the Division pharmacy benefits manager, by entities performing statutory functions related to the medical assistance programs such as the Drug Use Review Board, or by other entities in the conduct of program integrity activities applicable to the administration of the medical assistance programs. For these decisions made on behalf of the division in which the Division has legal authority to make the final decision in the matter, a provider may appeal the decision to the Division as an administrative review, and the Division may accept the review;¶
- (d) This rule does not apply to contract administration issues that may arise solely between the Division and a CCO or PHP. Those issues shall be governed by the terms of the applicable contract;¶
- (e) The Division provides limited provider appeals for CCO or PHP providers or non-participating providers concerning a decision by a CCO or PHP. In general, the relationship between a CCO or PHP and their providers is a contract matter between them. Client appeals are governed by the client appeal rules, not provider appeal rules.¶
- (A) The CCO or PHP provider seeking a provider appeal must have a current valid provider enrollment agreement with the Division and, unless the provider is a non-participating provider, must also have a contract with the CCO or PHP; and¶
- (B) The CCO or PHP provider or non-participating provider must have exhausted the applicable appeal procedure established by the CCO or PHP, and the request for provider appeal must include a copy of the CCO or PHP written decision that is being appealed and a copy of any CCO or PHP policy being applied in the appeal; and¶
- (C) The CCO or PHP provider appeal or non-participating provider appeal from a CCO or PHP decision is limited to issues related to the scope of coverage and authorization of services under the OHP, including whether services are included as covered on the OHA Prioritized List, guidelines, and in the OHP Benefit package. The Division provider appeal process does not include CCO or PHP payment or claims reimbursement amount issues, except in relation to non-participating provider matters governed by Division rule;¶
- (D) A timely provider request for appeal must be made within 30 calendar days from the date of the CCO or PHP's decision and include evidence that the PHP was sent a copy of the provider appeal. In every provider appeal involving a CCO or PHP decision, the CCO or PHP shall be treated as a participant in the appeal.¶
- (7) If a provider's request for appeal is not timely, the Division shall determine whether the failure to file the request was caused by circumstances beyond the control of the provider, provider applicant, or CCO or PHP provider. In determining whether to accept a late request for review, the Division requires the request to be supported by a written statement that explains why the request for review is late. The Division may conduct further inquiry as the Division deems appropriate. In determining timeliness of filing a request for review, the amount of time that the Division determines accounts for circumstances beyond the control of the provider is not counted. The Division may refer an untimely request to the Office of Administrative Hearings for a hearing on the question of timeliness.¶
- (8) The burden of presenting evidence to support a provider appeal is on the provider, provider applicant, CCO, or PHP provider:¶
- (a) Consistent with OAR 410-120-1360, payment on a claim shall be made only for services that are adequately documented and billed in accordance with OAR 410-120-1280 and all applicable administrative rules related to covered services for the client's benefit package and establishing the conditions under which services, supplies or items are covered, such as the OHA Prioritized List, medical appropriateness and other applicable standards;¶
- (b) Eligibility for enrollment and for continued enrollment is based on compliance with applicable rules, the information submitted or required to be submitted with the application for enrollment and the enrollment agreement, and the documentation required to be produced or maintained in accordance with OAR 410-120-1360.¶
- (9) Provider appeal proceedings, if any, shall be held in Salem, unless otherwise stipulated to by all parties and agreed to by the Division.
- Statutory/Other Authority: ORS 413.042
- Statutes/Other Implemented: ORS 413.042

AMEND: 410-120-1570

RULE SUMMARY: Remove reference to the comorbidity rule in OAR 410-141-3820, which is based on the nonfunded region of the Prioritized List. Replace reference to funded conditions with covered conditions. Update reference to (1) an individual medical necessity review; and (2) the OHA Prioritized List. Replace references to a "client" with "Member." Capitalize defined terms.

CHANGES TO RULE:

410-120-1570

Claim Re-Determinations ¶¶

(1) If a ~~p~~Provider disagrees with an initial claim determination made by the Division of Medical Assistance Program (~~Division~~), the ~~p~~Provider may request a review for re-determination of the denied claim payment. ¶¶

(2) This rule does not apply to determinations that: ¶¶

(a) Result in a "Notice of Action" that must be provided to the ~~OHP client~~Member. If the decision under review requires any notice to the ~~OHP client~~Member under applicable rules (OAR 410-120-1860, 410-141-3885), the procedures for notices and hearings must be followed; or ¶¶

(b) Are made by a CCO ~~or PHP~~ regarding services to a CCO ~~or PHP m~~Member. The ~~p~~Provider must contact the CCO ~~or PHP~~ in accordance with OAR 410-120-1560. ¶¶

(3) How to request a redetermination review: ¶¶

(a) To request a review, the ~~p~~Provider must submit a written request to the Division Provider Services Unit within 180 days of the original claim adjudication date; ¶¶

(b) The written request must include all information needed to adjudicate the claim or support changing the original claim determination, including but not limited to: ¶¶

(A) A detailed letter of explanation identifying the specific re-determination denial issue ~~and/or~~ alleged error; or both; ¶¶

(B) All relevant medical records and evidence-based practice data to support the position being asserted on review; ¶¶

(C) The specific service, supply or item being denied, including all relevant codes; ¶¶

(D) Detailed justification for the re-determination of the denied service; and ¶¶

(E) A copy of the original claim and a copy of the original denial notice or remittance advice that describes the basis for the claim denial under re-determination; ¶¶

(F) Any information and/or medical documentation pertinent to support the request and to obtain a resolution of the re-determination review dispute. ¶¶

(4) A ~~p~~Provider requesting a re-determination review must demonstrate one or more of the following reasons that would allow coverage in the particular case: ¶¶

(a) ~~A below the line condition/treatment pair is justified under the co-morbid rule OAR 410-141-3820;~~ ¶¶

(b) ~~A treatment that is part of a covered complex procedure and/or related to an existing funded condition;~~ ¶¶

(c) ~~A service/service that is Medically Necessary and Medically Appropriate when taking into consideration clinical factors, including but not limited on the HSC Prioritized List that may be covered under OAR 410-141-0480(10); to Comorbidities, during an individual medical necessity review;~~ ¶¶

(d) ~~A service that satisfies the Citizenship Waived Medical (CWM) emergency service criteria; treatment that is part of a covered complex procedure;~~ ¶¶

(e) ~~Medical documentation of applicable evidence-based practice literature that is consistent with the condition or service under review;~~ ¶¶

(f) ~~A service that satisfies the prudent layperson definition of emergency medical condition;~~ ¶¶

(g) ~~A service intended to prolong survival or palliate symptoms, due to expected length of life consistent with the HSC Statement of Intent for Comfort/Palliative Care;~~ ¶¶

(h) ~~A service that should be covered where denial was due to technical errors and omissions with the Oregon Health Services Commission's (HSC) HA Prioritized List of approved Health Services;~~ ¶¶

(i) ~~Misapplication of a fee schedule;~~ ¶¶

(j) ~~A denied duplicate claim that the provider believes were incorrectly identified as a duplicate;~~ ¶¶

(k) ~~Incorrect data items, such as provider number, use of a modifier or date of service, unit changes or incorrect charges;~~ ¶¶

(l) ~~Errors with the Medicaid Management Information System (MMIS), such as a code is missing in MMIS that the Oregon Health Services Commission (HSC) has placed on the is on the OHA Prioritized List of Health Services;~~ ¶¶

(m) ~~Services provided without the required prior-authorization, except for those authorizations subject to~~

provision outlined in OAR 410-120-1280(2)(a)(C);¶

(A) A covered diagnostic service.¶

(5) The Division will review all re-determination requests as follows:¶

(a) The review is based on the Division review of supplied documentation and applicable law(s);¶

(b) The Division may request additional information from the ~~p~~Provider that it finds relevant to the request under review;¶

(c) The Division does not provide a face-to-face or in-person meeting with ~~p~~Providers as part of the re-determination review process;¶

(d) The Division will notify a ~~p~~Provider requesting review that the re-determination request has been denied if:¶

(A) The ~~p~~Provider did not submit a timely request;¶

(B) The required information is not provided at the same time the request is submitted; or¶

(C) The ~~p~~Provider fails to submit any additional requested information within 14 business days of request.¶

(6) The Division's final decision under this rule is the final decision on a ~~a~~Appeal. Under ORS 183.484, this decision is an order in other than a contested case. ORS 183.484 and the procedures in OAR 137-004-0080 to 137-004-0092 apply to the Division's final decision under this rule.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

AMEND: 410-120-1600

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-120-1600

Provider Appeals - Contested Case Hearings ¶¶

- (1) A contested case procedure is a hearing that is conducted by the Office of Administrative Hearings where a contested case is appropriate and consistent with the provider appeal rules OAR 410-120-1560. If the request for contested case hearing was timely filed but should have been filed as a claim redetermination or administrative review, or client appeal, Division will refer the request to the proper appeal procedure and notify the Provider, provider applicant, CCO or PHP provider.¶¶
- (2) Contested case hearings are conducted in accordance with the Attorney General's model rules at OAR 137-003-0501 to 137-003-0700.¶¶
- (3) The party to a provider contested case hearing is the provider, provider applicant, CCO or PHP provider who requested the appeal. In the event that Division determines that a CCO or PHP provider is entitled to a Contested Case Hearing under OAR 410-120-1560, the CCO or PHP Provider and the CCO or PHP are parties to the hearing. A provider, CCO or PHP provider, CCO or PHP that is a corporation may be represented by any of the persons identified in ORS 410.190.¶¶
- (4) Informal conference: Division may notify the provider(s) provider applicant, CCO or PHP provider (and CCO or PHP, if applicable) of the time and place of an informal conference, without the presence of the Administrative Law Judge (ALJ). The purposes of this informal conference are:¶¶
- (a) To provide an opportunity to settle the matter;¶¶
- (b) To make sure the parties and the Authority understand the specific reason for the action of the hearing request;¶¶
- (c) To give the parties and the Authority an opportunity to review the information which is the basis for action;¶¶
- (d) To give the parties and the Authority the chance to correct any misunderstanding of the facts; and¶¶
- (e) The provider, provider applicant, CCO or PHP provider (or CCO, PHP, if applicable) may, at any time prior to the hearing date, request an additional informal conference with the Division and Authority representative(s), which may be granted if the Division finds at its sole discretion, the additional informal conference will facilitate the Contested Case Hearing process or resolution of disputed issues.¶¶
- (5) Contested Case Hearing: The Administrative Law Judge (ALJ) will conduct the contested case hearing using the Attorney General's Model Rules at OAR 137-003-0501 to 137-003-0700.¶¶
- (a) The burden of presenting evidence to support a provider appeal is on the provider, provider applicant, CCO or PHP provider that requested the appeal. Consistent with OAR 410-120-1360, payment on a claim will only be made for services that are adequately documented and billed in accordance with OAR 410-120-1280 and all applicable administrative rules related to covered services for the Client's benefit package and establishing the conditions under which services, supplies or items are covered, such as the OHA Prioritized List, medical appropriateness and other applicable standards.¶¶
- (b) Subject to Division approval under OAR 137-003-0525, the ALJ will determine the location of the Contested Case Hearings.¶¶
- (6) Proposed and Final Orders: The ALJ is authorized to serve a proposed order on all parties and the Division unless prior to the hearing, the Division notifies the ALJ that a final order may be served by the ALJ.¶¶
- (a) If the ALJ issues a proposed order, and the proposed order is adverse to a party, the party may file written exceptions to the proposed order to be considered by the Division, or the ALJ when the ALJ is authorized to issue the final order. The exceptions must be in writing and received by the Division, or the ALJ when the ALJ is authorized to issue the final order, not later than 10 calendar days after the date of the proposed order is issued by the ALJ. No additional evidence may be submitted without prior approval of Division.¶¶
- (b) The proposed order issued by the ALJ will become a final order if no exceptions are filed within the time specified in subsection (a) of this rule, unless the Division notifies the parties and the ALJ that Division will issue the final order. After receiving the exceptions or argument, if any, the Division may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, Division may issue an amended proposed order.¶¶
- (c) Procedures applicable to default orders for withdrawal of a hearing request, failure to timely request a hearing, failure to appear at a hearing, or other default, are governed by the Attorney General's Model Rules, OAR 137-003-0670 - 137-003-0672.¶¶
- (d) The final order is effective immediately upon being signed or as otherwise provided in the order.¶¶

(7) All Contested Case Hearing decisions are subject to the procedures established in OAR 137-003-675 to 137-003-0700 and to judicial review under ORS 183.482 in the Court of Appeals.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-120-1990

Telehealth

(1) The following definitions apply to the Oregon Health Authority (Authority) administrative rules applicable to the medical assistance programs:¶¶

(a) "Asynchronous" means not simultaneous or concurrent in time. For the purpose of this general rule, asynchronous telecommunication technologies for telehealth services may include audio and video, audio without video, client or member portal and may include remote monitoring. "Asynchronous" does not include voice messages, facsimile, electronic mail or text messages;¶¶

(b) "Audio only" means the use of audio technology, permitting real-time communication between a health care provider and a member for the purpose of diagnosis, consultation or treatment. "Audio only" does not include health services that are normally delivered by audio telephone technology and normally not billed as separate services by a health care provider, such as the sharing of laboratory results;¶¶

(c) "Meaningful access" as defined in Oregon Administrative Rule (OAR) 410-120-0000;¶¶

(d) "Synchronous" means an interaction between a provider and a client or member that occurs at the same time using an interactive technology. This may include audio only, video only, or audio with video and may include remote monitoring. Synchronous encounters are considered to meet face-to-face requirements;¶¶

(e) "Telecommunication technologies" means the use of devices and services for telehealth delivered services. These technologies include videoconferencing, store-and-forward imaging, streaming media including services with information transmitted using landlines, and wireless communications, including the Internet and telephone networks;¶¶

(f) "Telehealth" includes telemedicine and also includes the use of electronic information and telecommunications technologies to support remote clinical healthcare, client or member and professional health-related education, public health, and health administration;¶¶

(g) "Telemedicine" means the mode of delivering remote clinical health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a client or member's healthcare;¶¶

(h) "Trauma informed approach" as defined in OAR 410-120-0000;¶¶

(i) "Trauma informed services" as defined in OAR 410-120-0000.¶¶

(2) Communications may be between providers, or between one or more providers and one or more clients or members, family members, caregivers and guardians.¶¶

(3) School-Based Health Services required by the Individuals with Disabilities Education Act (IDEA), Section 504 Plan, under the Rehabilitation Act of 1973, or any other documented individualized health or behavioral health plan or as otherwise determined medically necessary provided in school programs and settings provided to eligible children in their education program settings by public education enrolled providers billing for these services to Medicaid are exempt from this rule. See chapter 410, division 133 for School-Based Health Services OARs.¶¶

(4) CCOs and FFS providers must ensure Oregon Health Plan (OHP) clients or members are offered a choice of how services are received, including services offered using telehealth modalities and in-person services, except where the Authority issues explicit guidance during a declared state of emergency or if a facility has implemented its facility disaster plan.¶¶

(5) Providers unable to offer in-person services:¶¶

(a) FFS providers unable to offer in-person services must develop, maintain and carry out policies and procedures to offer local provider options to a client or member when an in-person visit is clinically indicated or when the client or member requests in-person services. This may include but is not limited to care coordination or completing referral paperwork; ¶¶

(b) CCOs must ensure that providers unable to offer in-person services have access to the CCO Provider Directory. CCOs must include in applicable provider contract language that providers unable to offer in-person services shall, as needed, inform the CCO upon referring a member to another provider so the CCO can provide any care coordination services necessary to support the member in accessing care.¶¶

(6) Client or member choice and accommodation for telehealth must encompass the following standards and services:¶¶

(a) Providers who offer telehealth delivered services must offer meaningful access to services by completing a capacity assessment of the client or member in the use of specific approved methods of telehealth delivery that comply with accessibility standards including alternate formats, and provides the optimal quality of care for the

client or member given considerations of client or member access to necessary devices, access to a private and safe location, adequate internet, digital literacy, cultural appropriateness of services delivered using telehealth, and other considerations of client or member readiness to use telehealth;¶¶

(b) Providers must offer meaningful access to health care services for clients or members and their families who experience Limited English Proficiency (LEP) or hearing impairment by working with qualified or certified health care interpreters, to provide language access services as described in OAR 333-002-0040. These services must not be significantly restricted, delayed, or inferior as compared to programs or activities provided to English proficient individuals;¶¶

(c) Providers must collaborate with clients or members to identify and offer modalities for delivering health care services which best meets the needs of the member and considers the client or member's choice and readiness for the modality of service selected;¶¶

(d) Providers must offer telehealth services which are consistent with "meaningful access" as defined in OAR 410-120-0000.¶¶

(7) Privacy and security standards for telehealth services must be met by satisfying the following:¶¶

(a) Prior to the delivery of services using a telehealth modality, a client or member's written, oral, or recorded consent to receive services using a telehealth delivery method in the language that the client or member understands must be obtained and documented by the health system, clinic or provider in the client or member's health record. Consent must include an assessment of client or member readiness to access and participate in telehealth delivered services, including conveying all other options for receiving the health care service to the client or member. Consent must be updated at least annually thereafter. For clients or members and their families who experience LEP or hearing impairment clients, providers must use qualified or certified health care interpreters when obtaining client or member consent;¶¶

(b) Consistent with Oregon Revised Statute (ORS) 109.640, provision of birth control information and services using a telehealth modality must be provided to any person regardless of age without consent of parent or legal guardian;¶¶

(c) Consistent with ORS 109.640, provision of any other medical or dental diagnosis and treatment using a telehealth modality must be provided to any person 15 years of age or older without consent of parent or legal guardian;¶¶

(d) Consistent with ORS 109.675, provision of outpatient diagnosis or treatment of a mental or emotional disorder or a chemical dependency using a telehealth modality must be provided to any person 14 years of age or older without consent of parent or legal guardian;¶¶

(e) Consistent with ORS 109.610, provision of diagnosis or treatment of certain sexually transmitted infections using a telehealth modality must be provided to a person regardless of age without consent of parent or legal guardian;¶¶

(f) Services provided using a telehealth platform must comply with Health Insurance Portability and Accountability Act (HIPAA), <https://aspe.hhs.gov/report/health-insurance-portability-and-accountability-act-1996>, and with the Authority's Privacy and Confidentiality Rules (chapter 943, division 14) except as noted in section (10) below;¶¶

(g) There is no limitation on the location of the client or member;¶¶

(h) OHP enrolled providers may be located in any location where client or member privacy and confidentiality can be ensured;¶¶

(i) Persons providing interpretive services and supports must be in a location where client or member privacy and confidentiality can be ensured.¶¶

(8) Providers who offer telehealth delivery of services must meet the following requirements:¶¶

(a) Must hold an unencumbered Oregon license;¶¶

(b) Must be enrolled with the Authority as an Oregon Health Plan (OHP) provider, per OAR 410-120-1260;¶¶

(c) Must provide services using telehealth that are within their respective certification or licensing board's scope of practice and comply with telehealth requirements including, but not limited to:¶¶

(A) Documenting client or member and provider agreement of consent to receive services.¶¶

(B) Allowed physical locations of provider and client or member.¶¶

(C) Establishing or maintaining an appropriate provider-client or member relationship.¶¶

(d) Comply with HIPAA and the Authority's Privacy and Confidentiality Rules and security protections for the member in connection with the telehealth communication and related records requirements (OAR chapter 943 division 14 and 120, OAR 410-120-1360 and 1380, 42 CFR Part 2, if applicable, and ORS 646A.600 to 646A.628 (Oregon Consumer Identity Theft Protection Act) except as noted in section (10) of this rule;¶¶

(e) Obtain and maintain technology used in telehealth communication that is compliant with privacy and security standards in HIPAA and the Authority's Privacy and Confidentiality Rules described in subsection (A) except as noted in section (10) of this rule;¶¶

(f) Develop and maintain policies and procedures to prevent a breach in privacy or exposure of client or member health information or records (whether oral or recorded in any form or medium) to unauthorized persons and

timely breach reporting as described in OAR 943-014-0440;¶

(g) Maintain clinical and financial documentation related to telehealth services as required in OAR 410-120-1360 and any program specific rules in OAR chapter 309 and chapter 410;¶

(h) Comply with all federal and state statutes as required in OAR 410-120-1380.¶

(9) CCOs and the Authority will reimburse telehealth delivered services only when all the following requirements are met:¶

(a) Services provided-~~/must-/~~be covered-~~/~~services according to the client or member's benefit package as described in OAR 410-120-1210 and be provided in a manner compliant with relevant guideline notes included in-~~the Health Evidence Review Commission's OHA/~~Prioritized List of Health Services as described in OAR 410-141-3830;¶

(b) CCOs and the Authority must provide reimbursement for telehealth services at the same reimbursement rate as if the professional services were provided in person. ¶

(A) As a condition of reimbursement, FFS providers must agree to reimburse Certified and Qualified Health Care Interpreters (HCIs) as defined in OAR 333-002-0010 for interpretation services provided using telehealth at the same rate, excluding travel expenses, as if interpretation services were provided in-person. ¶

(B) CCOs must also reimburse Certified and Qualified HCIs for interpretation services provided using telehealth at the same reimbursement rate, excluding travel expenses, as if it were provided in person. These requirements do not supersede the CCOs direct agreement(s) with providers, including but not limited to, alternative payment methodologies, quality and performance measures or Value Based Payment methods described in the CCO contract. Administrative rules and CCO Direct Agreements do not supersede any federal or state requirements with regard to the provision and coverage of health care interpreter services.¶

(c) When allowed by individual certification or licensing board's scope of practice standards, qualifying telehealth delivered services are covered:¶

(A) When provided to established clients or members;¶

(B) When provided to new clients or members; and¶

(C) When consistent with applicable program specific OARs within chapter 410.¶

(d) All physical, behavioral and dental telehealth services except School Based Health Services (SBHS) must include Place of Service code 02 when the client or member is located in a place other than their home. When the client or member is located in their home, the claim must include Place of Service code 10;¶

(e) All claim types except dental services must include modifier 95 when the telehealth delivered service utilizes a real-time interactive audio and video telecommunication system. When provision of the same service utilizes a real-time interactive audio only, the claim must include modifier 93.¶

(10) In the event of a declared emergency or changes in federal requirements, the Authority may adopt flexibilities to remove administrative barriers and support telehealth delivered services:¶

(a) The Authority must follow guidance from the US Department of Health and Human Services (HHS) Office for Civil Rights (OCR), which may allow enforcement discretion related to privacy or security requirements.¶

(b) The Authority may expand network capacity through remote care and telehealth services provided across state lines.¶

(c) The Authority may exercise flexibilities in network adequacy requirements as described in OAR 410-141-3515. Statutory/Other Authority: ORS 413.032, 413.042

Statutes/Other Implemented: ORS 414.025, 414.065, 414.723

RULE SUMMARY: Revise reference to the comorbidity rule in OAR 410-141-3820, which is based on the nonfunded region of the Prioritized List. Remove reference to funded conditions. Remove reference to nonfunded region of the Prioritized List. Update reference to the OHA Prioritized List. Replace references to a “client” with “Member.” Capitalize defined terms.

CHANGES TO RULE:

410-121-0040

Prior Authorization Required for Drugs and Products ¶

- (1) Prescribing ~~p~~Practitioners shall obtain ~~p~~Prior ~~a~~Authorization (PA) for the drugs and categories of drugs requiring PA in this rule, using the procedures set forth in OAR 410-121-0060. ¶
- (2) Except as provided in section (3) of this rule, all drugs and categories of drugs including, but not limited to, those drugs and categories of drugs that require PA shall meet the following requirements for coverage: ¶
- (a) Each drug shall be prescribed ~~for conditions funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services (OAR 410-141-3820 through 410-141-3825). If the medication is for a non-covered diagnosis, the medication may not be covered unless there is a co-morbid condition for which coverage would be allowed in a manner consistent with the OHA Prioritized List of Health Services (OAR 410-141-3820 through 410-141-3825).~~ The use of the medication shall meet corresponding treatment guidelines and be included within the ~~client~~Member's ~~b~~Benefit ~~p~~Package of ~~e~~Covered ~~s~~Services and not otherwise excluded or limited; ¶
- (b) Each drug shall also meet other criteria applicable to the drug or category of drug in these pharmacy ~~p~~Provider rules, including PA requirements imposed in this rule. ¶
- (3) The Division shall grant exceptions to section (2) of this rule when coverage is required through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as set forth in chapter 410 division 151. ¶
- (4) The Authority may require PA for individual drugs and categories of drugs to ensure that the drugs prescribed are ~~indicated for conditions funded by OHP and~~ consistent with the OHA Prioritized List of Health Services and its corresponding treatment guidelines (see OAR 410-141-38230). The drugs and categories of drugs that the Authority requires PA for this purpose are found in the Oregon Medicaid Fee-for-Service Prior Authorization Approval Criteria (PA Criteria guide) July-/1, 2026 adopted and incorporated by reference and found at <https://www.oregon.gov/oha/HSD/OHP/Pages/Policy-Pharmacy.aspx>. ¶
- (5) The Authority may require PA for individual drugs and categories of drugs to ensure ~~m~~Medically ~~a~~Appropriate use or to address potential ~~client~~Member safety risk associated with the particular drug or category of drug, as recommended by the Pharmacy & Therapeutics Committee (P&T) and adopted by the Authority in this rule. The drugs and categories of drugs for which the Authority requires PA for this purpose are found in the Pharmacy PA Criteria Guide. ¶
- (6) New drugs shall be evaluated when added to the weekly upload of the First Databank drug file: ¶
- (a) If the new drug is in a class where current PA criteria apply, all associated PA criteria shall be required at the time of the drug file load; ¶
- (b) ~~If the new drug is indicated for a condition below the funding line on the Prioritized List of Health Services, PA shall be required to ensure that the drug is prescribed for a condition funded by OHP; ¶~~
- ~~(c) PA criteria for all new drugs shall be reviewed by the DUR/P&T Committee. ¶~~
- (7) PA shall be obtained for brand name drugs that have two (2) or more generically equivalent products available and that are not determined Narrow Therapeutic Index drugs by the DUR/P&T Committee: ¶
- (a) Immunosuppressant drugs used in connection with an organ transplant shall be evaluated for narrow therapeutic index within 180 days after United States patent expiration; ¶
- (b) Manufacturers of immunosuppressant drugs used in connection with an organ transplant shall notify the Authority of patent expiration within 30 days of patent expiration for section (5)(a) of this rule to apply; ¶
- (c) Criteria for approval are: ¶
- (A) If criteria established in section (4) or (5) of this rule applies, follow that criteria; ¶
- (B) If section (7)(a) of this rule does not apply, the prescribing ~~p~~Practitioner shall document that the use of the generically equivalent drug is medically contraindicated and provide evidence that either the drug has been used and has failed or that its use is contraindicated based on evidence-based peer reviewed literature that is appropriate to the ~~client~~Member's medical condition. ¶
- (8) PA shall be obtained for non-preferred Preferred Drug List (PDL) products in a class evaluated for the PDL except in the following cases: ¶

- (a) The drug is a mental health drug as defined in OAR 410-121-0000; or
 - (b) The original prescription is written prior to 1/1/10; or
 - (c) The prescription is a refill for the treatment of seizures, cancer, HIV, or AIDS; or
 - (d) The prescription is a refill of an immunosuppressant.
- (9) PA may not be required:
- (a) When the prescription ingredient cost plus the dispensing fee is less than the PA processing fees as determined by the Authority; or
 - (b) For over-the-counter (OTC) covered drugs when prescribed for conditions covered under OHP; or
 - (c) If a drug is in a class not evaluated from the Practitioner-Managed Prescription Drug Plan under ORS 414.334.
- Statutory/Other Authority: ORS 413.032, 413.042, 414.065, 414.330 - 414.414, 414.312, 414.316, 414.325
Statutes/Other Implemented: 414.065, 414.334, 414.361, 414.371, 414.353, 414.354, 414.325, 414.369

AMEND: 410-121-0147

RULE SUMMARY: Remove references to a funding line on the Prioritized List. Remove reference to nonfunded region of the Prioritized List. Replace references to a "client" with "Member." Capitalize defined terms.

CHANGES TO RULE:

410-121-0147

Exclusions and Limitations ¶

(1) The following items are not covered for payment by the Division of Medical Assistance Programs (Division) ~~Pharmaceutical Services Program~~; ¶

~~(a) Except as provided in section (2) of this rule, drug products for diagnoses below the funded line on the Health Evidence Review Commission (HERC) Prioritized List of Health Services or an excluded service under Oregon Health Plan (OHP) coverage;~~ ¶

~~(b) Pharmaceutical Services Program;~~ ¶

~~(a)~~ Home pregnancy kits; ¶

~~(e)~~ Fluoride for individuals over 18 years of age; ¶

~~(d)~~ Expired drug products; ¶

~~(e)~~ Drug products from non-rebatable manufacturers, with the exception of selected oral nutritionals, vitamins, and vaccines; ¶

~~(f)~~ Active Pharmaceutical Ingredients (APIs) and Excipients as described by Centers for Medicare and Medicaid (CMS); ¶

~~(g)~~ Drug products that are not assigned a National Drug Code (NDC) number; ¶

~~(h)~~ Drug products that are not approved by the Food and Drug Administration (FDA); ¶

~~(i)~~ Drug products dispensed for Citizenship Waived Medical (CWM) ~~client~~ Member benefit type except when prescribed as an emergency medical service as defined by OAR 410-134-0003(3). The CWM benefit plan ended on June 30, 2023; ¶

~~(j)~~ Drug Efficacy Study Implementation (DESI) drugs (see OAR 410-121-0420); ¶

~~(k)~~ Medicare Part D covered drugs or classes of drugs for ~~fully eligible client~~ Dual eligible ~~client~~ Members (see OAR 410-120-1200 & 410-120-1210). ¶

~~(l)~~ Drug products prescribed to establish or reestablish fertility or pregnancy; ¶

~~(m)~~ Drug products when prescribed for the treatment of sexual or erectile dysfunction; ¶

~~(n)~~ Drug products when prescribed for weight loss; and ¶

~~(o)~~ Drug products when primarily prescribed for cosmetic purposes or hair growth. ¶

(2) The Division shall cover drug products ~~for diagnoses below the funded line on the HERC Prioritized List of Health Services~~ when such coverage is required through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as set forth in Chapter 410 Division 151. ¶

(3) The Division shall cover drug products from non-rebateable manufacturers under any one or a combination of the following circumstances: ¶

(a) Coverage is required through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as set forth in Chapter 410 Division 151; ¶

(b) The drug is a vaccine; or ¶

(c) The drug is an oral nutritional or vitamin selected for coverage by the Division. ¶

(4) Effective on or after April 1, 2008, Section 1903(i) of the Social Security Act requires that written (nonelectronic) prescriptions for covered outpatient drugs for ~~Medicaid client~~ members be executed on a tamper-resistant pad in order to be eligible for federal matching funds. To meet this requirement, the Division shall only reimburse for covered Medicaid outpatient drugs only when the written (nonelectronic) prescription is executed on a tamper-resistant pad, or the prescription is electronically submitted to the pharmacy. ¶

(5) Drugs requiring a skilled medical professional for safe administration shall be billed by the medical professional's office; unless otherwise specified by the Division.

Statutory/Other Authority: ORS 413.042, ORS 414.065

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Remove references to a funding line on the Prioritized List. Update reference to the OHA Prioritized List. Update reference to an individual medical necessity review. Replace references to a "client" with "Member."
Capitalize defined terms.

CHANGES TO RULE:

410-122-0080

Conditions of Coverage, Limitations, and Restrictions ¶

(1) For EPSDT ~~b~~Beneficiaries (as defined in OAR 410-151-0001) and ~~client~~Members in the Young Adults with Special Health Care Needs or "YSHCN" program (as defined in OAR 410-200-0455): The EPSDT program covers all ~~m~~Medically ~~n~~Necessary and ~~m~~Medically ~~a~~Appropriate services needed to correct or ameliorate health conditions, or to improve the ~~client~~Member's ability to grow, develop, or participate in school, regardless of placement on or inclusion in the OHA Prioritized List of Health Services. Coverage for medical equipment and supplies shall not be denied without an individual review for ~~m~~Medical ~~n~~Necessity and ~~m~~Medical ~~a~~Appropriateness, as defined in OAR 410-151-0001. / ¶

(2) For ~~client~~Members age 21 and older: The Division may pay for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) when the item meets all criteria in these rules, including all of the following conditions. The item: / ¶

(a) Is either approved, registered, or listed as a medical device by the Food and Drug Administration (FDA), and the item is otherwise generally considered to be safe and effective for the intended purpose. In the event of delay in FDA approval ~~and/or~~ registration, the Division shall review purchase options on a case-by-case basis; / ¶

(b) Is ~~m~~Medically ~~a~~Appropriate and ~~m~~Medically ~~n~~Necessary for the ~~client~~Member, as defined in OAR 410-120-0000; / ¶

(c) Is primarily and customarily used to serve a medical purpose; / ¶

(d) Is generally not useful to an individual in the absence of medical disability, illness, or injury; / ¶

(e) Is suitable for use in a ~~client~~Member's home or any non-institutional setting in which normal life activities take place; / ¶

(f) Specifically for durable medical equipment, the item can withstand repeated use and can be reusable or removable; / ¶

(g) Meets the coverage criteria as specified in this division and subject to service limitations of the Division rules; / ¶

(h) Is requested in relation to ~~a~~ / ¶

(A) A diagnosis and treatment pair that is above the funding line appears on the OHA Prioritized List of Health Services and is consistent with associated treatment guidelines; on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List of Health Services or List) or qualify for coverage under OAR 410-141-3820(11); r ¶

(B) A diagnosis and treatment pair not appearing on the OHA Prioritized List that is determined to be Medically Necessary and Medically Appropriate when taking into consideration clinical factors, including but not limited to Co-morbidities, during an individual medical necessity review. / ¶

(i) Is included in the Oregon Health Plan (OHP) ~~client~~Member's ~~b~~Benefit ~~p~~Package of ~~e~~Covered ~~s~~Services; / ¶

(j) Is the least costly, ~~m~~Medically ~~a~~Appropriate item that meets the medical needs of the ~~client~~Member; / ¶

(k) Coverage is not restricted to items covered by the Medicare program. / ¶

(3) Conditions for Medicare-Medicaid Services: / ¶

(a) If Medicare is the primary payer and Medicare denies payment, an ~~a~~Appeal to Medicare must be filed timely prior to submitting the claim to the Division for payment. If Medicare denies payment based on failure to submit a timely appeal, the Division may reduce any amount the Division determines could have been paid by Medicare; / ¶

(b) If Medicare denies payment on ~~a~~Appeal, the Division shall apply DMEPOS coverage criteria in this rule to determine whether the item or service is covered under the OHP; / ¶

(c) Providers are not required to bill Medicare for items that are statutorily excluded and therefore not recognized as part of a covered Medicare benefit (e.g., incontinence supplies, bath equipment, adaptive car seats, standing frames). Prior ~~a~~Authorization criteria for these services/items must still be met. / ¶

(4) The Division may not cover DMEPOS items when the item or the use of the item is: / ¶

(a) Not primarily medical in nature (e.g., personal hygiene items, sporting and fitness equipment, equipment used with the primary intent to physically restrain an individual); / ¶

(b) For personal comfort or convenience of the ~~client~~Member or caregiver; / ¶

(c) A self-help device; / ¶

(d) Not therapeutic or diagnostic in nature; / ¶

- (e) Used for precautionary reasons; / ¶
- (f) Inappropriate for clientMember use in the home or non-institutional setting (e.g., institutional equipment like an oscillating bed); / ¶
- (g) For a purpose where the medical effectiveness is not supported by evidence-based clinical practice guidelines; or / ¶
- (h) Reimbursed as part of the bundled rate in a Nursing Facility as described in OAR 411-070-0085 or as part of a home and community-based care waiver service or by any other public, community, or Third-Party Resource. / ¶
- (5) Codes that are identified in these rules or in fee schedules are provided as a mechanism to facilitate payment for covered items and supplies consistent with OAR 410-122-0186, but codes do not determine coverage. If Prior aAuthorization is required, the request for reimbursement shall document that Prior aAuthorization was obtained in compliance with the rules in this division. / ¶
- (6) DMEPOS pProviders shall have documentation on file that supports coverage criteria are met. / ¶
- (7) Billing records shall demonstrate that the pProvider has not exceeded any limitations and restrictions in the DMEPOS rules. The Division may require additional claim information from the pProvider consistent with program integrity review processes. / ¶
- (8) Documentation described in sections (5), (6), and (7) above shall be made available to the Division upon request. / ¶
- (9) The Division fee schedule provides a list of HCPCS codes that may be covered when criteria are met. Coverage may be provided for HCPCS codes that do not appear on the fee schedule with an individual mMedical aAppropriateness review as outlined in this rule. / ¶
- (10) Some bBenefit pPackages do not cover equipment and supplies (see OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System). / ¶
- (11) Buy-ups are prohibited. Advanced Beneficiary Notices (ABN) constitute a buy-up and is prohibited. Refer to ~~the Division General Rule~~ OARs (chapter 410, division 120) for specific rules on buying-up. / ¶
- (12) Equipment purchased by the Division for a clientMember becomes the property of the clientMember. / ¶
- (13) Rental charges starting with the initial dDate of sService, regardless of payer, apply to the purchase price. / ¶
- (14) A pProvider who supplies rented equipment shall continue furnishing the same item throughout the entire rental period, except under documented reasonable circumstances. / ¶
- (15) Before renting, pProviders must consider purchase for long-term requirements. / ¶
- (16) The Division may not pay DMEPOS pProviders for medical supplies separately while a clientMember is under a home health plan of care and covered home health care services. / ¶
- (17) The Division may not pay DMEPOS pProviders for medical supplies separately while a clientMember is under a Hospice plan of care where the supplies are included as part of the written plan of care and for which payment may otherwise be made by Medicare, the Division, or other carrier. / ¶
- (18) Separate payment may not be made to DMEPOS pProviders for equipment and medical supplies provided to a clientMember when the cost of the items is already included in the capitated (per diem) rate paid to a facility or organization. / ¶
- (19) Certain specified medical equipment and supplies require a face-to-face examination as described in these rules consistent with federal regulations at 42 CFR 440.70. See OAR 410-122-0090 for the face-to-face requirements. / ¶
- (20) Non-contiguous out-of-state DMEPOS pProviders may seek Medicaid payment only under the following circumstances: / ¶
 - (a) Medicare/Medicaid clientMembers: / ¶
 - (A) For Medicare covered services and then only Medicaid payment of a clientMember's Medicare cost-sharing expenses for DMEPOS services when all of the following criteria are met: / ¶
 - (i) ClientMember is a qualified Medicare beneficiary (QMB); / ¶
 - (ii) Service is covered by Medicare; / ¶
 - (iii) Medicare has paid on the specific code. Prior aAuthorization is not required. / ¶
 - (B) Services not covered by Medicare: / ¶
 - (i) Only when the service or item is not available in the State of Oregon, and this is clearly substantiated by supporting documentation from the prescribing pPractitioner and maintained in the DMEPOS pProvider's records; / ¶
 - (ii) Some examples of services not reimbursable to a non-contiguous eOut-of-state pProvider include but are not limited to incontinence supplies, grab bars; / ¶
 - (iii) Services billed must be covered under the OHP; / ¶
 - (iv) Services provided and billed to the Division shall be in accordance with all applicable Division rules. / ¶
 - (b) Medicaid-only clientMembers: / ¶
 - (A) For a specific Oregon Medicaid clientMember who is temporarily outside Oregon and only when the prescribing pPractitioner has documented that a delay in service may cause clientMember harm; / ¶

(B) For foster care or subsidized adoption children placed out of state; / ¶

(C) Only when the service or item is not available in the ~~S~~state of Oregon, and this is clearly substantiated by supporting documentation from the prescribing ~~p~~Practitioner and maintained in the DMEPOS ~~p~~Provider's records; / ¶

(D) Services billed must be covered under the OHP; / ¶

(E) Services provided and billed to the Division shall be in accordance with all applicable Division rules. / ¶

(21) An individual ~~m~~Medical ~~a~~Appropriateness review shall be conducted by the Division or CCO on requests for any DMEPOS item, related supplies, or services that are not already identified as covered by the Division in these rules or the Division fee schedule; / ¶

(a) The DME supplier must submit clinical documentation from the prescribing ~~p~~Practitioner that is ~~client~~Member-specific and demonstrates there is no equally effective, less costly covered item or service that meets the ~~client~~Member's medical needs; / ¶

(b) The ~~client~~Member's prescribing ~~p~~Practitioner must certify that the less costly alternatives have been tried and failed or could be reasonably expected to fail or is inappropriate for the ~~client~~Member; / ¶

(c) Documentation must support that the requested item or service is ~~m~~Medically ~~a~~Appropriate and ~~m~~Medically ~~n~~Necessary as defined in OAR Chapter 410 Division 120 for adult beneficiaries and / OAR Chapter 410 Division 151 for EPSDT ~~b~~Beneficiaries. An EPSDT ~~b~~Beneficiary is an individual under the age of 21 who is covered by the Oregon Health Plan (OHP) or an individual in the Young Adults with Special Health Care Needs (YSHCN) program as defined in OAR 410-200-0455; / ¶

(d) Requests under this section for ~~clients enrolled in CCO~~CCO Members shall be directed to the CCO in which the ~~client~~CCO member is enrolled, in accordance with OAR 410-122-0040(2). / ¶

(22) See ~~General Rules~~ OAR 410-120-1200 Excluded Services and Limitations for more information on general scope of coverage and limitations. /

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: 414.065

AMEND: 410-122-0090

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-122-0090

Face-to-Face Encounter Requirements (for Fee-For-Service Clients) ¶¶

(1) For initial ordering of DME items identified in section (9) of this rule and for those DME items identified as requiring a face-to-face visit in Division 122 rules, an in-person or telehealth face-to-face encounter that is related to the primary reason the client requires the medical equipment or supplies must occur no more than six (6) months prior to the start of services. ¶¶

(2) Telehealth encounters used to satisfy the face-to-face encounter requirement for a DMEPOS item must meet the requirements outlined in the OHA Prioritized List of Health Services Telehealth, Teleconsultations, and Online/Telephonic Services Ancillary Guideline Note. ¶¶

(3) The face-to-face encounter shall be conducted and documented by one of the following practitioners: ¶¶

(a) A physician; ¶¶

(b) A nurse practitioner or clinical nurse specialist, as authorized by State law; ¶¶

(c) A physician associate, as authorized by and in accordance with State law; ¶¶

(d) A licensed practitioner of the healing arts acting within the scope of practice authorized under State law; ¶¶

(4) The practitioner responsible for ordering the services must document the face-to-face encounter and clinical findings supporting that the client was evaluated or treated for a condition that supports the need for the DME items ordered within six months prior to completing the written order; ¶¶

(5) If a dually eligible client is evaluated for medical equipment or supplies under Medicare and transitions to Medicaid, the Medicare face-to-face encounter documentation shall meet the Medicaid face-to-face requirement. ¶¶

(6) The DME supplier shall maintain and provide documentation of the qualifying face-to-face encounter, written order/prescription, and the supporting documentation when the item requires prior authorization or at the Division's request. ¶¶

(7) The supporting documentation shall include subjective and objective client-specific information used for diagnosing, treating, and managing a clinical condition for which the DMEPOS is ordered. ¶¶

(8) The DME supplier shall have documentation on file that supports all coverage criteria in the DMEPOS rules are met. ¶¶

(9) The list of required DME items subject to face-to-face requirements is posted and maintained by CMS. Please refer to the CMS.gov website for an active link to this list.

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: 414.065

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-122-0202

Positive Airway Pressure (PAP) Devices for Adult Obstructive Sleep Apnea ¶

(1) Indications and limitations of coverage and medical appropriateness: ¶

(a) The Division may cover the initial three (3) month trial period of a positive airway pressure (PAP) device for treatment of obstructive sleep apnea (OSA)/when the client meets the conditions of coverage in OAR 410-122-0080 and when all the following guidelines and criteria are met: ¶

(A) The client has a face-to-face clinical evaluation by the treating practitioner prior to a sleep test to assess the client for obstructive sleep apnea; ¶

(B) The client has a home sleep test or a polysomnogram performed in a facility-based laboratory to test for obstructive sleep apnea and the type of sleep test performed meets all CMS requirements for a valid sleep test and in accordance with the OHA Prioritized List of Health Services Diagnostic Testing for Obstructive Sleep Apnea (OSA) Guideline Note; ¶

(C) The client demonstrates a positive diagnosis of OSA, as defined in the OHA Prioritized List of Health Services Treatment of Sleep Apnea Guideline Note; and ¶

(D) The client or their caregiver has received instruction from the supplier in the proper use and care of the PAP device equipment and accessories. ¶

(b) Prior Authorization (PA) is not required for PAP device (E0601) rental and the purchase of prescribed accessories during the initial three (3) month trial period. The DMEPOS provider is responsible to ensure all requirements in this rule are met. ¶

(c) A Bi-level Positive Airway Pressure (BiPAP) device without backup rate (E0470) may be covered for treatment of OSA when the following criteria are met: ¶

(A) Criteria in (1)(a)(A)-(D) of this rule; and ¶

(B) A Continuous Positive Airway Pressure (CPAP) or Automatic Positive Airway Pressure (APAP) device (E0601) has been tried and proven ineffective or there is documentation of medical contraindication to E0601 devices as determined by the treating practitioner. Ineffective use is defined as documented failure to meet therapeutic goals using a CPAP/APAP device during the titration period of a facility-based study or during home use despite optimal therapy (i.e., proper mask selection and fitting and appropriate pressure settings); ¶

(C) If a CPAP/APAP device is tried and found ineffective during the initial facility-based titration or three (3) month home trial, substitution of a BiPAP does not require a new face-to-face clinical evaluation or sleep test; ¶

(D) If a CPAP/APAP device has been used for more than three (3) months and the client is switched to a BiPAP, a clinical re-evaluation must occur, but a new sleep test is not required. A new three (3) month trial shall begin for use of the BiPAP. ¶

(d) PA is not required for BiPAP device (E0470) rental and purchase of prescribed accessories during the initial three (3) month trial period. The DMEPOS provider is responsible to ensure all requirements in this rule are met. ¶

(2) Continued Coverage of PAP device (PA Required): ¶

(a) Purchase or ongoing rental of a PAP device (E0601 or E0470) beyond the three-month trial period may be covered when the conditions of coverage have been met per the OHA Prioritized List of Health Services Treatment of Sleep Apnea Guideline Note. The DMEPOS provider must submit the following documentation, with request for authorization, prior to the fourth (4th) date of service: ¶

(A) A face-to-face re-evaluation visit conducted by the treating practitioner no sooner than the thirty-first (31st) day but no later than the ninety-first (91st) day after initiating therapy that supports client's clinical benefit, compliance, and demonstrates symptoms of OSA are improved; and ¶

(B) Objective evidence of adherence to use of the PAP device, including a summary of PAP compliance report through a direct download of usage. PAP compliance report data can be documented by the treating practitioner in the clinical re-evaluation. Adherence to therapy is defined as use of PAP four (4) hours or more per night on seventy percent (70%) of nights during a consecutive thirty (30) day period anytime during the first three months of initial usage; ¶

(C) If the clinical re-evaluation by the treating practitioner does not occur until after the ninety-first (91st) day but the re-evaluation demonstrates the client is compliant, as defined in this rule, and benefiting from PAP therapy at the time of their re-evaluation, the provider shall submit a PA request for continued coverage. The request for authorization shall include the following documentation: ¶

(i) The clinical re-evaluation with the treating practitioner that demonstrates the client is compliant, as defined in

this rule, and benefiting from the PAP therapy at the time of the re-evaluation; and/¶

(ii) Objective evidence of adherence to use of the PAP device, including a summary of PAP compliance report through a direct download of usage, at the time of the client's re-evaluation. PAP compliance report data can be documented by the treating practitioner in the clinical re-evaluation. Adherence to therapy is defined as use of PAP four (4) hours or more per night on seventy percent (70%) of nights during a consecutive thirty (30) day period prior to client's re-evaluation.-/¶

(D) If there is a break in billing of sixty (60) days or more between the end of the trial period and the request to purchase or continue renting the PAP device, the provider shall also supply current objective evidence of adherence to use of the PAP device from the date the prior authorization request to resume coverage is submitted; /¶

(i) Adherence to therapy is defined as use of PAP four (4) hours or more per night on seventy percent (70%) of nights during a consecutive thirty (30) day period;/¶

(ii) Capped rental period begins the date the equipment is dispensed and shall not extend beyond the thirteenth (13th) consecutive month;/¶

(b) If objective data does not support compliance and efficacy, extending the trial period beyond the third month may be approved on a case-by-case basis by the appropriate authorizing unit. To ask for an exception, the DMEPOS provider must submit the following documentation with the prior authorization request:/¶

(A) Documentation of a face-to-face visit with the treating practitioner clearly specifying a treatment plan with measurable goals to improve adherence to treatment; and/¶

(B) Objective evidence of PAP use, including a PAP summary report through direct download of usage;/¶

(C) The trial period may extend up to a maximum of two (2) months to allow the client to achieve compliance, as defined in this rule, and therapeutic benefit;/¶

(D) Purchase or ongoing rental of a PAP device (E0601 or E0470) beyond the two (2) month extended trial period may be covered when the conditions for continued coverage have been met. Submit the following documentation with request for prior authorization:-/¶

(i) A face-to-face clinical re-evaluation conducted by the treating practitioner which documents the following:-/¶

(I) Client is compliant and benefiting from PAP therapy; and/¶

(II) Objective evidence of adherence to use of the PAP device, including a summary of PAP compliance report through a direct download of usage;-/¶

(ii) Adherence to therapy is defined as use of PAP four (4) hours or more per night on seventy percent (70%) of nights during a consecutive thirty (30) day period anytime during the two (2) month extended rental period./¶

(E) If there is a break in billing of sixty (60) days or more between the end of the extended trial period and the request to purchase or continue renting the PAP device, the provider shall also supply current objective evidence of adherence to use of the PAP device from the date the prior authorization request to resume coverage is submitted;/¶

(i) Adherence to therapy is defined as use of PAP four (4) hours or more per night on seventy percent (70%) of nights during a consecutive thirty (30) day period;/¶

(ii) Capped rental period begins the date the equipment is dispensed and shall not extend beyond the thirteenth (13th) consecutive month./¶

(c) Clients who fail their PAP trial, may be eligible to re-qualify for a PAP device trial but must have both:/¶

(A) Face-to-face clinical re-evaluation by the treating practitioner to determine etiology of the failure to respond to PAP therapy; and/¶

(B) Repeat sleep test in a facility-based setting if deemed necessary by the treating practitioner. This may be a repeat diagnostic titration or split night study in accordance with the OHA Prioritized List of Health Services Diagnostic Testing for Obstructive Sleep Apnea (OSA) Guideline Note./¶

(d) For a client using a PAP device prior to Oregon Health Plan (OHP) enrollment, continuing coverage for the device and related accessories may be authorized on a case-by-case basis upon submission and review of the following required documentation:/¶

(A) Record of initial delivery date when the PAP equipment was dispensed; and/¶

(B) Documentation from the client's treating practitioner to support the diagnosis of OSA and that coverage criteria in this rule are met in accordance with the OHA Prioritized List of Health Services Treatment of Sleep Apnea Guideline Note; and/¶

(C) A facility-based polysomnogram report or home sleep test that meets all CMS requirements for a valid sleep test in accordance with the OHA Prioritized List of Health Services Diagnostic Testing for Obstructive Sleep Apnea (OSA) Guideline Note; and-/¶

(D) Objective evidence of client's ongoing adherence to PAP therapy at the time the prior authorization for continued coverage is requested. Adherence to therapy is defined as use of PAP four (4) hours or more per night on seventy percent (70%) of nights during a consecutive thirty (30) day period./¶

(e) The continued rental of PAP equipment and the purchase of related accessories shall not be reimbursed, under

any circumstance, when client is not using the equipment or non-compliant with its use;— ¶

(A) It is the provider's responsibility to monitor appropriate and effective use of the device as ordered by the treating practitioner; and— ¶

(B) When the equipment is not being used as prescribed or member is non-compliant with its use, it is the provider's responsibility to—stop billing for the continued rental of the equipment and the purchase of related accessories and supplies.— ¶

(3) Accessories:— ¶

(a) Either a non-heated (E0561) or heated (E0562) humidifier is covered and reimbursed separately when ordered by the treating practitioner for use with a covered PAP device (E0470, E0601). No PA is required;— ¶

(b) Accessories are separately reimbursable at the time of initial issue and when replaced. For replacement of accessories beyond initial issue:— ¶

(A) Suppliers are required to verify the PAP or BiPAP device is still in use; — ¶

(B) Regardless of utilization, a supplier must not dispense more than a three (3) month quantity of accessories;— ¶

(C) Automatic shipments on a pre-determined basis, even if authorized by the client or designee, are not allowed. An order refill does not have to be approved by the ordering practitioner. However, a client or their caregiver must request specific ongoing PAP supplies and accessories, subject to rule limitations and requirements, before they are dispensed. The DMEPOS provider shall not automatically dispense a quantity of supplies and accessories on a predetermined regular basis, even if the client has "authorized" this in advance;— ¶

(c) The following represents the usual maximum number of accessories expected to be medically appropriate:— ¶

(A) A4604 - 1 per 3 months;— ¶

(B) A7027 - 1 per 3 months;— ¶

(C) A7028 - 2 per month;— ¶

(D) A7029 - 2 per month;— ¶

(E) A7030 - 1 per 3 months;— ¶

(F) A7031 - 1 per month;— ¶

(G) A7032 - 2 per month;— ¶

(H) A7033 - 2 per month;— ¶

(I) A7034 - 1 per 3 months;— ¶

(J) A7035 - 1 per 6 months;— ¶

(K) A7036 - 1 per 6 months;— ¶

(L) A7037 - 1 per 3 months;— ¶

(M) A7038 - 2 per month;— ¶

(N) A7039 - 1 per 6 months;— ¶

(O) A7046 - 1 per 6 months.— ¶

(4) Replacement of PAP Device:— ¶

(a) For PAP devices initially covered through the Oregon Health Plan, a replacement PAP may be covered on a case-by-case basis in accordance with OAR 410-122-0184. The DMEPOS provider must submit the following documentation with the PA request:— ¶

(A) An order for the replacement PAP device from the treating practitioner; and— ¶

(B) A face-to-face clinical evaluation by the treating practitioner that documents the present medical need for replacement and confirms the beneficiary continues to use and benefit from the PAP device.— ¶

(b) For PAP devices not initially covered through the Oregon Health Plan, a replacement PAP may be covered on a case-by-case basis in accordance with OAR 410-122-0184. The DMEPOS provider must submit records to support the client meets criteria in (1)(a)(A)-(D) of this rule and the following documentation with the PA request:— ¶

(A) An order for the replacement PAP device from the treating practitioner;— ¶

(B) A face-to-face clinical evaluation by the treating practitioner that documents the present medical need for replacement and confirms the beneficiary continues to use and benefit from the PAP device; and— ¶

(C) Name of prior DMEPOS provider and the date the PAP device was initially issued.— ¶

(5) Prior authorization is obtained from the same authorizing authority as specified in OAR 410-122-0040. PA is required for the following:— ¶

(a) All subsequent—rentals or purchase of a PAP device starting with the fourth (4th) month date of service;— ¶

(b) Quantities of PAP accessories that exceed their usual maximum number as defined in (3)(c)(A-O);— ¶

(c) A replacement PAP device.— ¶

(6) Mandibular advancement devices (oral appliances) may be covered for those for whom CPAP fails or is contraindicated. A face-to-face clinical evaluation with the treating practitioner is required to document the presence of either condition and the medical necessity for the device. If a custom fabricated device is prescribed, the practitioner's evaluation must also include why a less costly prefabricated device will not meet the client's needs. No PA is required.— ¶

(7) Reimbursement:— ¶

- (a) Rental charges apply toward purchase;┐
 - (b) Capped rental period begins the date the equipment is dispensed and shall not extend beyond the thirteenth (13th) consecutive month;┐
 - (c) Equipment is considered purchased either upon completion of the capped rental period, after the Division fee schedule purchase price is met, or when the actual charge from the provider is met, whichever is less;┐
 - (d) Accessories are separately reimbursable at the time of initial issue.┐
 - (8) Documentation Requirements:┐
 - (a) For services requiring PA, submit documentation that supports coverage criteria and guidelines in this rule are met;┐
 - (b) Medical records and documentation to support the client meets criteria and conditions of coverage in this rule must be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request.┐
 - (9) For children and youth 18 years old or younger: the Division may cover a positive airway pressure (PAP) device for treatment of obstructive sleep apnea (OSA) when the criteria and conditions of coverage in the OHA Prioritized List of Health Services Treatment of Sleep Apnea Guideline Note are met.┐
 - (10) A Respiratory Assist Device (RAD) with backup rate (E0471) is not medically indicated for the treatment of obstructive sleep apnea. Coverage, coding, and documentation requirements are addressed in OAR 410-122-0205 Respiratory Assist Devices.┐
 - (11) Table 122-0202 - PAP Devices.
- Statutory/Other Authority: ORS 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0202.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:

<https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=340153>

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-122-0250

Breast Pumps ¶

(1) Indications and limitations of coverage and medical appropriateness: ¶

(a) In accordance with the OHA Prioritized List of Health Services Breastfeeding Support and Supplies Guideline Note, the Division may cover a breast pump and supplies for postpartum women when a pump is necessary to establish or maintain milk production in order to maximize availability of breast milk to the baby; ¶

(b) For cases in which there is a medical indication for breast pumps, the pumps shall be supplied whenever possible within 24 hours to allow for continued milk production; ¶

(c) The client or caregiver shall receive instruction from the supplier in the proper use and care of the breast pump within 48 hours of receiving the equipment; ¶

(d) The rental of a hospital grade breast pump (E0604) may be covered for up to three (3) months when prescribed for use in the home; ¶

(e) A breast pump shall not be provided until a need is determined following birth; ¶

(f) A breast pump shall not be provided if it is known that mother is using a substance that is contraindicated while breastfeeding and does not plan to stop its use; ¶

(g) Replacement supplies may be covered when medically necessary and for the continued operation of the breast pump (E0602, E0603, E0604); ¶

(A) Reimbursement of medically necessary replacement supplies are limited to replacement tubing, replacement adapter, replacement cap for breast pump bottle, replacement breast shield and protector, replacement polycarbonate bottle, replacement locking ring, replacement valve, and a disposable collection and storage bag for breast milk (any size, any type); ¶

(B) The following represents the usual number of supplies expected to be medically appropriate; however, the quantity and frequency of replacement supplies shall be determined by the treating practitioner: ¶

(i) A4281 - 2 units per year; ¶

(ii) A4282 - 2 units per year; ¶

(iii) A4283 - 2 units per year; ¶

(iv) A4284 - 2 sets per year; ¶

(v) A4285 - 2 units per year; ¶

(vi) A4286 - 2 units per year; ¶

(vii) A4287 - 186 units per month; ¶

(viii) A4288 - 2 units per year. ¶

(2) Prior Authorization (PA): A PA is obtained from the same authorizing authority as specified in OAR 410-122-0040. PA is required for the following: ¶

(a) Replacement of the breast pump due to loss, theft, or irreparable damage in accordance with OAR 410-122-0184; ¶

(b) Replacement supplies not identified in this rule; ¶

(c) Rental of a hospital grade breast pump (E0604) beyond the third month; ¶

(3) The following services are not considered medically necessary: ¶

(a) Accessories not necessary for the operation of a breast pump (for example, travel bags, nursing bras, bra pads, breast feeding pillows, etc.); ¶

(b) An electric breast pump for the comfort and convenience of the mother; ¶

(c) Purchase of heavy-duty hospital grade breast pumps; ¶

(d) Replacement parts covered under the manufacturer's and/or supplier's warranty. ¶

(4) Reimbursement: ¶

(a) Reimbursement for the purchase of a single-user electric breast pump (E0603) includes all parts and supplies necessary for the operation of the electric pump;/ ¶

(b) Reimbursement for the purchase of a manual breast pump (E0602) includes all parts and supplies necessary for the operation of the manual pump; ¶

(c) Reimbursement for the first month's rental of a hospital grade breast pump (E0604) includes all parts and supplies necessary for the operation of the hospital grade pump; ¶

(d) Replacement supplies, other than breast shields, are not reimbursable at the time of purchase or rental; ¶

(e) Rental charges apply to purchase; ¶

(f) Reimbursement is limited to the purchase of one (1) breast pump per pregnancy; ¶

(5) Documentation: ¶

(a) For services requiring prior authorization, submit documentation that supports coverage criteria in this rule are met; ¶

(b) Medical records and documentation to support the client meets criteria and conditions of coverage in this rule must be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request. ¶

(6) Procedure Codes: ¶

(a) E0602 - Breast pump, manual, any type - purchase only; ¶

(b) E0603 - Breast pump, electric (AC and/or DC), any type - purchase only; ¶

(c) E0604 - Breast pump, hospital grade, electric (AC and/or DC), any type - rental only; ¶

(d) A4281 - Tubing for breast pump, replacement; ¶

(e) A4282 - Adapter for breast pump, replacement; ¶

(f) A4283 - Cap for breast pump bottle, replacement; ¶

(g) A4284 - Breast shield and splash protector for use with breast pump, replacement; ¶

(h) A4285 - Polycarbonate bottle for use with breast pump, replacement; ¶

(i) A4286 - Locking ring for breast pump, replacement; ¶

(j) A4287 - Disposable collection and storage bag for breast milk, any size, any type; ¶

(k) A4288 - Valve for breast pump, replacement.

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.065

AMEND: 410-122-0300

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-122-0300

Light Therapy ¶

(1) Indications and limitations of coverage and medical appropriateness: The Division may cover home phototherapy when medically appropriate and for the following conditions: ¶

(a) For a term or near-term infant whose elevated bilirubin is not due to a primary hepatic disorder or other hemolytic disorder that requires inpatient care and the American Academy of Pediatrics Clinical Practice Guidelines for management of hyperbilirubinemia with phototherapy are met; the Practice Guidelines are available at <https://publications.aap.org/pediatrics/article/150/3/e2022058859/188726/Clinical-Practice-Guideline-Revision-Management-of?autologincheck=redirected> ¶

(b) For severe inflammatory skin conditions identified in the OHA Prioritized List of Health Services Severe Inflammatory Skin Disease Guideline Note. ¶

(2) Prior Authorization (PA): ¶

(a) Ultraviolet light therapy systems (E0691, E0692, E0693, E0694): ¶

(b) Refer to the OHA Prioritized List of Health Services Severe Inflammatory Skin Disease Guideline Note for coverage guidelines. ¶

(3) Reimbursement: ¶

(a) Reimbursement for the monthly rental of a phototherapy light (E0202) includes supplies, instruction, training, and twenty-four (24) hour on-call service necessary for the operation and effective use of the equipment; ¶

(b) Reimbursement for the monthly rental or purchase of the ultraviolet light therapy systems includes supplies, instruction, and training necessary for the operation and effective use of the equipment; ¶

(c) Rental charges apply to purchase. ¶

(4) Documentation Requirements: ¶

(a) For services that require PA: Submit documentation for review that supports conditions of coverage as specified in this rule are met; ¶

(b) Documentation and medical records to support the client meets all criteria and conditions of coverage in this rule must be kept on file with the DMEPOS provider and shall be made available to the Division upon request. ¶

(5) Procedure Codes: ¶

(a) E0202 - Phototherapy (bilirubin) light with photometer ¶

(b) E0691 - Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less ¶

(c) E0692 - Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel ¶

(d) E0693 - Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel/ ¶

(e) E0694 - Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection ¶

(f) A4633 - Replacement bulb/lamp for ultraviolet light therapy system, each ¶

(6) Table 122-0300 Light Therapy.

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0300.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:

<https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=340157>

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-122-0560

Urological and Bowel Supplies ¶

(1) Indications and Limitations of Coverage and Medical Appropriateness: ¶

(a) The Division may cover the following urinary catheters, external urinary collection devices, and medically appropriate related supplies when used to drain or collect urine for a client who has permanent urinary incontinence or permanent urinary retention; ¶

(b) Indwelling Catheters (A4311-A4316, A4338-A4346): ¶

(A) No more than one (1) catheter per month for routine catheter maintenance; ¶

(B) Non-routine catheter changes when documentation substantiates medical appropriateness, such as for the following indications: ¶

(i) Catheter is accidentally removed (e.g., pulled out by client); ¶

(ii) Catheter malfunctions (e.g., balloon does not stay inflated, hole in catheter); ¶

(iii) Catheter is obstructed by encrustation, mucous plug, or blood clot; ¶

(iv) History of recurrent obstruction or urinary tract infection for which it has been established that an acute event is prevented by a scheduled change frequency of more than once (1) per month; ¶

(C) A specialty indwelling catheter (A4340) or an all-silicone catheter (A4344, A4312, or A4315) when documentation in the client's medical record supports the medical appropriateness for that catheter rather than a straight Foley type catheter with coating (such as recurrent encrustation, inability to pass a straight catheter, or sensitivity to latex); ¶

(D) A three-way indwelling catheter either alone (A4346) or with other components (A4313 or A4316) only if continuous catheter irrigation is medically appropriate; ¶

(c) Catheter Insertion Tray (A4310-A4316, A4353, and A4354): ¶

(A) Only one (1) insertion tray per episode of indwelling catheter insertion; ¶

(B) One (1) intermittent catheter with insertion supplies (A4353) per episode of medically appropriate sterile intermittent catheterization; ¶

(d) Urinary Drainage Collection System (A4314-A4316, A4354, A4357, A4358, A5102, and A5112): ¶

(A) For routine changes of the urinary drainage collection system as noted in Table 122-0560-1; ¶

(B) Additional charges for medically appropriate non-routine changes when the documentation substantiates the medical appropriateness (e.g., obstruction, sludging, clotting of blood, or chronic, recurrent urinary tract infection); ¶

(C) A vinyl leg bag (A4358) or a latex leg bag (A5112) only for clients who are ambulatory or are chair or wheelchair bound; ¶

(e) Intermittent Irrigation of Indwelling Catheters: ¶

(A) Supplies for the intermittent irrigation of an indwelling catheter when they are used on an as needed (non-routine) basis in the presence of acute obstruction of the catheter; ¶

(B) Routine intermittent irrigations of a catheter are not covered; ¶

(C) Routine irrigations are defined as those performed at predetermined intervals; ¶

(D) Covered supplies for medically appropriate non-routine irrigation of a catheter include either an irrigation tray (A4320) or an irrigation syringe (A4322), and sterile water/saline (A4217); ¶

(f) Continuous Irrigation of Indwelling Catheters: ¶

(A) Supplies for continuous irrigation of a catheter when there is a history of obstruction of the catheter and the patency of the catheter cannot be maintained by intermittent irrigation in conjunction with medically appropriate catheter changes; ¶

(B) Continuous irrigation as a primary preventative measure (i.e., no history of obstruction) is not covered; ¶

(C) Documentation must substantiate the medical appropriateness of catheter irrigation and in particular continuous irrigation as opposed to intermittent irrigation; ¶

(D) The records must also indicate the rate of solution administration and the duration of need; ¶

(E) Covered supplies for medically appropriate continuous bladder irrigation include a three-way Foley catheter (A4313, A4316, and A4346), irrigation tubing set (A4355), and sterile water/saline (A4217): ¶

(i) The Division may cover one (1) irrigation tubing set per day for continuous catheter irrigation; ¶

(ii) Continuous irrigation is considered a temporary measure and may only be covered for up to 14 days; ¶

(g) Intermittent Catheterization: Intermittent catheter supplies when basic coverage criteria are met and the client

or caregiver can perform the procedure: ¶

(A) For each episode of covered catheterization, one (1) catheter (A4351, A4352) and an individual packet of lubricant (A4332); or ¶

(B) One (1) sterile intermittent catheter kit (A4353) when the client requires catheterization and meets one of the following criteria (i-iv): ¶

(i) The client is immunosuppressed. Examples of immunosuppressed clients include (but are not limited) clients who are: ¶

(I) On a regimen of immunosuppressive drugs post-transplant; ¶

(II) On cancer chemotherapy; ¶

(III) Has AIDS; ¶

(IV) Has a drug-induced state such as chronic oral corticosteroid use; ¶

(ii) The client has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization; ¶

(iii) The client is a pregnant, spinal cord-injured female with neurogenic bladder (for duration of pregnancy only); ¶

(iv) The client has had distinct, recurrent urinary tract infections, while on a program of sterile intermittent catheterization with A4351/A4352 and sterile lubricant (A4332), twice within the 12-month period prior to the initiation of sterile intermittent catheter kits. A urinary tract infection means a urine culture with greater than 10,000 colony forming units of a urinary pathogen; and documentation in the client's medical records of concurrent presence of one or more of the following signs, symptoms or laboratory findings: ¶

(I) Fever (oral temperature greater than 38.3 C [100.4 F]); ¶

(II) Systemic leukocytosis; ¶

(III) Change in urinary urgency, frequency, or incontinence; ¶

(IV) Appearance of new or increase in autonomic dysreflexia (sweating, bradycardia, blood pressure elevation); ¶

(V) Physical signs of prostatitis, epididymitis, orchitis; ¶

(VI) Increased muscle spasms; ¶

(VII) Pyuria (greater than five white blood cells [WBCs] per high-powered field); ¶

(C) The kit code (A4353) must be used for billing even if the components are packaged separately rather than together as a kit; ¶

(h) Coude (Curved) Tip Catheters: ¶

(A) Use of a Coude (curved) tip catheter (A4352) in female clients is rarely medically appropriate; ¶

(B) For any client, when a Coude tip catheter is dispensed and billed, there must be specific documentation in the client's medical record why a Coude tip catheter is required rather than a straight tip catheter; ¶

(i) External Catheters/Urinary Collection Devices: ¶

(A) Male external catheters (condom-type) or female external urinary collection devices for clients who have permanent urinary incontinence when used as an alternative to an indwelling catheter; ¶

(B) Coverage for male external catheters (A4349) is limited to 35 per month; ¶

(C) Greater utilization of these devices must be accompanied by documentation of medical appropriateness; ¶

(D) Male external catheters (condom-type) or female external urinary collection devices are not covered for clients who also use an indwelling catheter; ¶

(E) The Division may cover specialty type male external catheters such as those that inflate or that include a faceplate (A4326) or extended wear catheter systems (A4348) only when documentation substantiates the medical appropriateness for such a catheter; ¶

(F) Coverage of female external urinary collection devices is limited to one metal cup (A4327) per week or one (1) pouch (A4328) per day; ¶

(j) Anal Irrigation System and Catheter: ¶

(A) Refer to the OHA Prioritized List of Health Services Anal Irrigation Systems Guideline Note for coverage guidelines; ¶

(B) Utilization and frequency are determined by the treating practitioner. The following represents the usual maximum number of kits and catheters expected to be medically appropriate: ¶

(i) A4459 - 1 unit (one unit = one kit) every three (3) months; ¶

(ii) A4453 - 31 units (one unit = one catheter) per month; ¶

(k) Miscellaneous Supplies: ¶

(A) Appliance cleaner (A5131): One (1) unit of service (16 oz) per month when used to clean the inside of certain urinary collecting appliances (A5102, A5105, A5112); ¶

(B) One (1) external urethral clamp or compression device (A4356) every three (3) months or sooner if the rubber/foam casing deteriorates; ¶

(C) Adhesive catheter anchoring devices (A4333, three per week) and catheter leg straps (A4334, one (1) per month) for indwelling urethral catheters; ¶

(D) A catheter/tube anchoring device (A5200) separately payable when it is used to anchor a covered suprapubic

tube or nephrostomy tube; ¶¶

(E) Non-Sterile Gloves (A4927): four (4) units are allowed per month, one (1) unit = 100 each (50 pairs); ¶¶

(I) The following services are not covered: ¶¶

(A) Creams, salves, lotions, barriers (liquid, spray, wipes, powder, paste) or other skin care products (A6250); ¶¶

(B) Catheter care kits (A9270); ¶¶

(C) Adhesive remover (A4456, A4455); ¶¶

(D) Catheter clamp or plug (A9270); ¶¶

(E) Disposable underpads, all sizes, diapers or incontinence garments, any type, disposable or reusable unless authorized under 410-122-0630 Incontinent Supplies; ¶¶

(F) Drainage bag holder or stand (A9270); ¶¶

(G) Urinary suspensory without leg bag (A4359); ¶¶

(H) Measuring container (A9270); ¶¶

(I) Urinary drainage tray (A9270); ¶¶

(J) Gauze pads (A6216-A6218) and other dressings; ¶¶

(K) Other incontinence products not directly related to the use of a covered urinary catheter or external urinary collection device (A9270); ¶¶

(L) Irrigation supplies that are used for care of the skin or perineum of incontinent clients; ¶¶

(M) Syringes, trays, sterile saline, or water used for routine irrigation; ¶¶

(N) Disposable external urethral clamp or compression device, with pad and/or pouch, each. ¶¶

(2) Guidelines: ¶¶

(a) Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected within three (3) months. A determination that there is no possibility that the client's condition may improve sometime in the future is not required. If the medical records, including the judgment of the attending treating practitioner, indicate the condition is of long and indefinite duration (ordinarily at least three (3) months), the test of permanence is considered met; ¶¶

(b) A urinary intermittent catheter with insertion supplies (A4353) is a kit, which includes a catheter, lubricant, gloves, antiseptic solution, applicators, drape, and a tray or bag in a sterile package intended for single use; ¶¶

(c) Adhesive strips or tape used with male external catheters are included in the allowance for the code and are not separately payable; ¶¶

(d) Catheter insertion trays (A4310-A4316, A4353, and A4354) that contain component parts of the urinary collection system, (e.g., drainage bags and tubing) are inclusive sets and payment for additional component parts may be allowed only per the stated criteria in each section of the policy; ¶¶

(e) Extension tubing (A4331) may be covered for use with a latex urinary leg bag (A5112) and is included in the allowance for codes A4314, A4315, A4316, A4354, A4357, A4358, and A5105 and A4331 cannot be separately billed with these codes; ¶¶

(f) Use A4333 when used to anchor an indwelling urethral catheter; ¶¶

(g) Use code A5105 when billing for a urinary suspensory with leg bag; ¶¶

(h) Replacement leg straps (A5113, A5114) are used with a urinary leg bag (A4358, A5105, or A5112). These codes are not used for a leg strap for an indwelling catheter; ¶¶

(i) A4326 is a male external catheter with an integrated collection chamber that does not require the use of an additional leg bag. ¶¶

(3) Documentation Requirements: ¶¶

(a) For services requiring prior authorization (PA), submit documentation which supports coverage criteria as specified in this rule are met; ¶¶

(b) Intermittent Catheterization: ¶¶

(A) The practitioner's order must indicate the actual number of times intermittent catheterization is performed per day; ¶¶

(B) The client's medical records must support the number of times per day intermittent catheterization is performed; ¶¶

(c) When requesting quantities of supplies greater than the maximum units specified in this rule, submit documentation supporting the medical appropriateness for the higher utilization to the appropriate authorization authority for PA; ¶¶

(d) Documentation, which supports condition of coverage requirements for codes billed in this rule, must be kept on file by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request; ¶¶

(e) A client's medical records must support the justification for supplies billed to the Division. ¶¶

(4) Table 122-0560-1, Maximum Quantity of Supplies. ¶¶

(5) Table 122-0560-2. ¶¶

(6) Table 122-0560-3, Procedure Codes.

Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0560.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:

<https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=340167>

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-122-0630

Incontinent Supplies ¶¶

(1) The/Division may cover incontinent supplies for urinary or fecal incontinence in accordance with the OHA Prioritized List of Health Services Fecal Incontinence Guideline Note and as follows: ¶¶

(a) Category I Incontinent Supplies: For up to 200 units (any code or product combination in this category) per month, unless documentation supports the medical appropriateness for a higher quantity. For quantities over this limit a prior authorization shall be required. When requesting multiple Category I product types (i.e., diapers and liners) that exceed the allowable, prior authorization and documentation as described in (4)(a)(D) of this rule are required; ¶¶

(b) Category II Underpads: ¶¶

(A) Disposable underpads: For up to 100 units (any combination of T4541 and T4542) per month, unless documentation supports the medical appropriateness for a higher quantity, up to a maximum of 150 units per month; ¶¶

(B) Reusable/washable underpads: For up to eight units (any combination of T4537 and T4540) in a 12-month period; ¶¶

(C) Category II Underpads may be separately payable with Category I Incontinent Supplies with documentation that supports medical appropriateness for the use of this product; ¶¶

(D) T4541 and T4542 are not separately payable with T4537 and T4540 for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for eight reusable/washable underpads on a given date of service, a client would not be eligible for disposable underpads for the subsequent 12 months; ¶¶

(c) Category III Washable Protective Underwear: ¶¶

(A) For up to 12 units in a 12 month period; ¶¶

(B) Category III Washable Protective Underwear is not separately payable with Category I Incontinent Supplies for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for 12 units of T4536 on a given date of service, a client would not be eligible for Category I Incontinent Supplies for the subsequent 12 months; ¶¶

(d) The following services require PA: ¶¶

(A) A4335 (Incontinence supply; miscellaneous); ¶¶

(B) T4543 (Disposable incontinence product, brief/diaper, bariatric); ¶¶

(C) T4544 (Disposable incontinence product, protective underwear/pull-on); ¶¶

(D) Quantity of supplies greater than the amounts listed in this rule as the maximum monthly utilization (e.g., more than 200 units per month of Category I Incontinent Supplies, or two (2) units per month of gloves). ¶¶

(2) Incontinent supplies are not covered: ¶¶

(a) For nocturnal enuresis; or ¶¶

(b) For children under the age of three (3). ¶¶

(3) A provider may only submit A4335 when there is no definitive Healthcare Common Procedure Coding System (HCPCS) code that meets the product description. ¶¶

(4) Documentation requirements: ¶¶

(a) The client's medical records shall support the medical appropriateness for the services provided or being requested by the medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider, including, but not limited to: ¶¶

(A) For all categories, the medical reason and condition causing the incontinence; and ¶¶

(B) When a client is using urological or ostomy supplies at the same time as incontinent products specified in this rule, information that clearly corroborates the overall quantity of supplies needed to meet bladder and bowel management is medically appropriate; ¶¶

(C) For all clients not residing in their home subsequent PA requests for incontinence product(s), the provider shall submit a log with the PA request. This log shall be the most recent log for the client documenting the number and frequency of incontinent product changes; ¶¶

(D) PA requests for multiple Category I incontinence product types for the same client (i.e. doubling up) shall be accompanied by adequate explanation from the client's ordering practitioner to explain why a single, more appropriate, incontinence product cannot be used; ¶¶

(E) Although PA is not required for Category II incontinence products, the DMEPOS provider shall have

documentation on file from the prescribing practitioner supporting medical appropriateness; ¶
(F) When requesting PA for T4543 (Bariatric Brief/Diaper) or T4544 (Protective underwear/pull-on), submit product information showing that the item is size XXL or larger. The request shall also include client weight and measurements that support the use of the bariatric incontinence product (e.g., client weight, waist and hip size). These items are manually priced following payment methodology outlined in OAR 410-122-0186. ¶
(b) For services requiring PA, submit documentation as specified in (4)(a)(A)-(E) and (F); ¶
(c) The DMEPOS provider is required to keep supporting documentation on file and make available to the Division on request. ¶
(5) Quantity specification: ¶
(a) For PA and reimbursement purposes, a unit count for Category I-III codes is considered as a single or individual piece of an item and not as a multiple quantity; ¶
(b) If an item quantity is listed as number of boxes, cases or cartons, the total number of individual pieces of that item contained within that respective measurement (box, case or carton) shall be specified in the unit column on the PA request. See table 122-0630-2; ¶
(c) For gloves (Category IV Miscellaneous), 100 each (50 pairs) equal one (1) unit. ¶
(6) Table 122-0630-1, Incontinent Supplies ¶
(7) Table 122-0630-2, Incontinent Supplies - Counting Units and Pieces
Statutory/Other Authority: ORS 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0630.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
<https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=340169>

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-122-0658

Gradient Compression Stockings/Sleeves ¶¶

(1) Indications and Limitations of Coverage and Medical Appropriateness: ¶¶

(a) The Division may cover gradient compression stockings/sleeves for the following indications when the client meets the conditions of coverage in OAR 410-122-0080 and when all the following guidelines and criteria are met: ¶¶

(A) Ulceration due to chronic venous insufficiency; ¶¶

(B) Varicose veins with ulcer or inflammation; ¶¶

(C) Phlebitis/thrombophlebitis; ¶¶

(D) Deep vein thrombosis (DVT) prophylaxis during pregnancy and postpartum or immobilization due to surgery, trauma, or debilitation; ¶¶

(E) Funded lymphedema conditions even in the absence of ulcers or other complications; and ¶¶

(F) Edema following a covered surgery, fracture, burns, or other trauma; ¶¶

(b) A gradient compression stocking may be covered when it is used to secure a primary dressing over an open venous stasis ulcer that is currently being treated by a practitioner and requires medically necessary debridement and when the gradient stocking delivers compression less than 50 mmHg; ¶¶

(c) Two (2) gradient compression stockings/sleeves per affected limb may be provided at dispensing (the second one is for use while the first one is being laundered); ¶¶

(d) Replacement stockings/sleeves are limited to two (2) per affected limb every six (6) months. Requests for quantities that exceed this amount require detailed medical documentation (e.g., change in size, unusual drainage, wear that renders them ineffective); ¶¶

(e) Custom-made gradient compression stockings/sleeves require prior authorization with documentation that supports that the treating practitioner has considered ready-made gradient compression stockings/sleeves and the reason why they will not meet the medical needs of the client. ¶¶

(f) The following services are not covered: ¶¶

(A) Antiembolism stockings (A4490-A4510); ¶¶

(B) Garter belts (A6544); ¶¶

(C) Stockings/sleeves for the following conditions: ¶¶

(i) Solely for the purpose of air travel; ¶¶

(ii) Treatment of non-funded lymphedema conditions; ¶¶

(iii) Venous insufficiency without stasis ulcers; ¶¶

(D) Support hose (pantyhose). ¶¶

(2) Gradient compression garments, related supplies and accessories are covered for the treatment of lymphedema and in accordance with the OHA Prioritized List of Health Services Lymphedema Guideline Note. ¶¶

(a) A quantity of three (3) daytime garments or wraps per body area are allowed once every six (6) months; ¶¶

(b) A quantity of two (2) nighttime garments per body area are allowed once every two (2) years; ¶¶

(c) Replacements needed in cases of loss, theft, or irreparable damage may be covered by the Division in accordance with OAR 410-122-0184; ¶¶

(d) Lymphedema compression treatment items include the following: ¶¶

(A) Standard and custom daytime gradient compression garments; ¶¶

(B) Nighttime gradient compression garments; ¶¶

(C) Gradient compression wraps with adjustable straps; ¶¶

(D) Compression bandaging systems; ¶¶

(E) Accessories such as zippers, liners/linings, padding or fillers that are necessary for the effective use of a gradient compression garment or wrap; ¶¶

(F) Refer to Table 122-0658 for a complete list of HCPCS codes; ¶¶

(G) DMEPOS providers shall refer to the product classification list on the Medicare Pricing, Data Analysis and Coding (PDAC) contractor website for coding verification and HCPCS codes used to identify specific durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). ¶¶

(3) Documentation Requirements: Medical records that support the conditions of coverage are met, as specified in this rule, shall be kept on file by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to the Division on request. ¶¶

(4) Table 122-0658

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-122-0658.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:

<https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=340172>

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-123-1060

Definitions and Acronyms ¶¶

The acronyms and definitions within this rule specifically pertain to dental services. This rule does not include an exhaustive list of acronyms and definitions that apply to dental services. All Authority rules are intended to be used in conjunction with the General Rules for Oregon Health Plan (OHP) OAR 410 division 120 and the OAR 410 division 141. Other acronyms and definitions that apply to dental services are found in OARs 410-141-3500, 410-120-0000, 410-200-0015, and Chapter 410, Division 130.¶¶

- (1) "Alveoplasty" is a dental procedure often performed following a tooth extraction, to help recreate the natural contour of the gums and jaw that may have been lost due to bone loss from tooth extraction, or for another reason.¶¶
- (2) "Ancillary Services" has the meaning provided in OAR 410-120-0000. ¶¶
- (3) "Anesthesia Services" has the meaning provided in OAR 410-120-0000.¶¶
- (4) "Anterior teeth" are referred to as the front teeth. Permanent (adult) teeth are also referred to by numbers and differentiated by upper and lower: ¶¶
 - (a) The upper anterior teeth are indicated by the numbers 6, 7, 8, 9, 10, 11; and ¶¶
 - (b) The lower anterior teeth are indicated by the numbers 22, 23, 24, 25, 26, 27.¶¶
- (5) "Apexification" is a dental treatment provided on permanent teeth when the roots of the teeth are incompletely formed, to encourage development and formation of the root.¶¶
- (6) "Apicoectomy" involves the removal of a tooth's root tip and surrounding tissue.¶¶
- (7) "Billing" definition and requirements are provided in OAR 410-120-1280.¶¶
- (8) "By Report" (BR) has the meaning provided in OAR 410-120-0000.¶¶
- (9) "Canine teeth" are anterior teeth that are pointed. In addition to numbered permanent (adult) teeth, primary (baby) teeth are also referred to by letters and differentiated between upper and lower:¶¶
 - (a) Primary upper canine teeth are indicated by the letters C, H;¶¶
 - (b) Primary lower canine teeth are indicated by the letters M, R;¶¶
 - (c) Permanent upper canine teeth are indicated by the numbers 6, 11; and¶¶
 - (d) Permanent lower canine teeth are indicated by the numbers 22, 27.¶¶
- (10) "Clinically Appropriate" has the meaning provided in OAR 410-120-0000.¶¶
- (11) "Compact Of Free Association (COFA)" Dental Program is a dental-only enrollment type under the Oregon Health Plan (OHP) as defined in OAR 410-200-0445. ¶¶
- (12) "Composite restorations" are white, tooth-colored fillings. ¶¶
- (13) "Concurrent needs" means simultaneously having a diagnosed need and other characteristics as listed that may affect service delivery. ¶¶
- (14) "Coordinated Care Organization (CCO)" has the meaning provided in OAR 410-141-3500. ¶¶
- (15) "Covered Services" has the meaning provided in OAR 410-120-0000.¶¶
- (16) "Current Dental Terminology (CDT)" codes are the alphanumeric codes that identify a specific dental procedure, as designated by the federal government, and used by the American Dental Association. Current Dental Terminology, © 2025 American Dental Association. All rights reserved.¶¶
- (17) "Dental" means teeth and supporting structures.¶¶
- (18) "Dental Hygienist" has the meaning provided in OAR 410-120-0000.¶¶
- (19) "Dental Hygienist with an Expanded Practice Dental Hygiene (EPDH) Permit" has the meaning provided in OAR 410-120-0000.¶¶
- (20) "Dental Practitioner (Practitioner)" means an individual licensed pursuant to state law to engage in the provision of dental services within the scope of the practitioner's license and certification.¶¶
- (21) "Dental Services" means services provided within the scope of practice as defined under state law, by or under the supervision of a dentist or dental hygienist or denture services provider within the scope of practice as defined under state law, by a denturist or dental hygienist with an Expanded Practice Permit (EPP).¶¶
- (22) "Dental Subcontractor" has the meaning provided in OAR 410-120-0000. ¶¶
- (23) "Dental Therapist" has the meaning provided in OAR 410-120-0000.¶¶
- (24) "Dentally Appropriate" has the meaning provided in OAR 410-120-0000.¶¶
- (25) "Dentist" has the meaning provided in OAR 410-120-0000.¶¶
- (26) "Denturist" has the meaning provided in OAR 410-120-0000.¶¶

- (27) "Distant Site" means the site where a dentist is being contacted for consultation by the originating site.¶
- (28) "Documentation" means dental services documentation which meets the requirements of the Oregon Dental Practice Act statutes, administrative rules for member records, and requirements of OAR 410-120-1360 Requirements for Financial, Clinical and Other Records, and any other documentation as outlined in OAR Chapter 410, Division 123 (Dental/Denturist Services).¶
- (29) "Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)" means the program described in OAR 410-151-0000.¶
- (30) "EPSDT Beneficiary" has the meaning provided in OAR 410-151-0001.¶
- (31) "Eligibility" has the meaning provided in OAR Chapter 410, Division 200.¶
- (32) "Emergency Dental Condition" means any incident involving the teeth or gums which may require immediate treatment to stop ongoing tissue bleeding, alleviate severe and sudden pain or infection, treat unusual swelling of the face or gums, or to preserve an avulsed (knocked out) tooth. For additional criteria, refer to "Emergency Medical Condition" provided in 410-120-0000.¶
- (33) "Emergency Dental Services" has the same meaning as "Dental Emergency Services" provided in OAR 410-120-0000. This meaning is synonymous with "emergency dental care" and "emergency oral health care."¶
- (34) "Endodontic" means relating to the inner tissues of teeth, otherwise known as the pulp or nerve. Endodontic treatments include pulpal therapy and root canal therapy.¶
- (35) "Fee-for-Service Provider" has the meaning provided in OAR 410-120-0000.¶
- (36) "First Tooth" is a curriculum aimed to reduce early childhood caries in Oregon.¶
- (37) "Fillings" are provided when an area of decay on a tooth is removed by a dental provider, leaving a hole or space that is then filled with a material.¶
- (38) "Gingivectomy" is the surgical removal of diseased gum tissue, to prevent damage to the bone.¶
- (39) "Gingivoplasty" is the surgical reshaping of gum tissue around the teeth.¶
- (40) "Health Care Interpreter (HCI)" Certified or Qualified, has the meaning given to those terms in ORS 413.550.¶
- (41) "Hemoglobin A1c (HbA1c) Testing" is a measure of glucose attached to red blood cells and directly relates to average blood glucose levels.¶
- (42) "Health Evidence Review Commission (HERC)" has the meaning provided in OAR 410-120-0000.¶
- (43) "Incisors" are anterior (front) teeth that have single, narrow edges. They are the four front, upper teeth, and the four front lower teeth.¶
- (a) Primary upper incisors are indicated by the letters D, E, F, G;¶
- (b) Primary lower incisors are indicated by the letters N, O, P, Q;¶
- (c) Permanent upper incisors are indicated by the numbers 7, 8, 9, 10; and;¶
- (d) Permanent lower incisors are indicated by the numbers 23, 24, 25, 26.¶
- (44) "Malocclusion" is a misalignment or incorrect relation of the upper and lower teeth when the jaw is closed.¶
- (45) "Mandibular" refers to the lower jaw and the lower teeth.¶
- (46) "Maxillary" refers to the upper jaw and the upper teeth.¶
- (47) "Maxillofacial" means relating to the face, head, neck or jaw. Treatments may be necessary due to trauma, disease, or congenital defects.¶
- (48) "Medical Practitioner" means an individual licensed pursuant to state law to engage in the provision of medical services within the scope of the practitioner's license and certification.¶
- (49) "Medically Necessary" has the meaning provided in OAR 410-120-0000.¶
- (50) "Medicament" means a substance or combination of substances intended to be pharmacologically active, specially prepared to be prescribed, dispensed, or administered to prevent or treat disease.¶
- (51) "Oral Health" refers to the health of teeth, gums, lips, tongue, inner cheeks, and the entire oral-facial system that allows us to smile, speak, and chew.¶
- (52) "Oral Health Services" refers to services offered to members for their improved oral health. The workforce involved in the services offered includes (but is not limited to) delivery systems staff, educational programs staff, licensed dental providers, dental assistants, and primary care providers such as doctors, nurses, and medical assistants.¶
- (53) "Oregon Health Authority (Authority)" means the organization that administers Medicaid in Oregon.¶
- (54) "Oregon Health Plan (OHP)" is the Medicaid program in Oregon, and has the meaning provided in OAR 410-120-0000.¶
- (55) "Originating Site" means the site where the member is located, and dental care providers are working and performing services in conjunction with a dentist who is not at that site, while using telehealth technology.¶
- (56) "Periapical X-rays" capture an image of an entire tooth, from the crown to the root tip.¶
- (57) "Periodontal scaling" and "root planing" refer to non-surgical treatments to remove plaque and tartar from teeth roots and gums.¶
- (58) "Periodontal" refers to the soft tissues supporting and surrounding teeth.¶
- (59) "Permanent teeth", often referred to as adult teeth, are the second set of teeth people get. There are 32

permanent teeth which include incisors, canines, and premolars, and molars. They are identified by the numbers 1 through 32.¶

(60) "Posterior teeth" are referred to as the back teeth: ¶

(a) Permanent upper posterior teeth are indicated by the numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16;¶

(b) Permanent lower posterior teeth are indicated by the numbers 17, 18, 19, 20, 21, 28, 29, 30, 31, 32;¶

(c) Primary upper posterior teeth are indicated by the letters A, B, I, J; and¶

(d) Primary lower posterior teeth are indicated by the letters S, T, K, L.¶

(61) "Practitioner" has the meaning provided in OAR 410-120-0000. ¶

(62) "Premolars" are permanent teeth that are positioned between the canines and molars:¶

(a) The upper premolar teeth are indicated by the numbers 4, 5, 12, 13; and¶

(b) The lower premolar teeth are indicated by the numbers 20, 21, 28, 29.¶

(63) "Prescriptions" means services as outlined in OAR 410-121-0144.¶

(64) "Primary Teeth" are also known as baby teeth. These are the first set of teeth that people get. There are 20 primary teeth that shall exfoliate (fall out) as the permanent teeth grow in. Primary teeth are indicated by the letters A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T. ¶

(65) "Prior Authorization (PA)" has the meaning provided in OAR 410-120-0000.¶

(66) "OHA Prioritized List of Health Services (OHA Prioritized List)" has the meaning provided in OAR 410-120-0000.¶

(67) "Procedure Codes" means Current Dental Terminology (CDT), unless otherwise noted. Codes listed in this rule and other documents incorporated in rule by reference are subject to change by the American Dental Association (ADA) without notification.¶

(68) "Prophylaxis" is a dental service to thoroughly clean the teeth.¶

(69) "Prosthodontics" refers to the replacement of missing or damaged teeth with artificial devices, most commonly dentures.¶

(70) "Provider" has the meaning provided in OAR 410-120-0000.¶

(71) "Pulpal regeneration" is a dental treatment used to restore the pulp of a diseased or damaged tooth.¶

(72) "Pulpal therapy" involves removing pulp from the crown of a primary tooth and treating it with medicament.¶

(73) "Record retention" means the schedule whereby providers must keep clinical information and financial records on file. ¶

(74) "Smiles for Life" is a national oral health curriculum that Oregon Medicaid has adopted to improve oral health access.¶

(75) "Standard of Practice" means what reasonable and prudent practitioners may do in the same or similar circumstances.¶

(76) "Teledentistry" means using electronic and telecommunications technologies, for the distance delivery of dental care services and clinical information designed to improve a member's health status and to enhance delivery of the health care services and clinical information.¶

(77) "Telehealth" has the meaning provided in OAR 410-120-0000.¶

(78) "Third Party Resources (TPR)" has the meaning provided in OAR 410-120-1280.¶

(79) "Urgent Dental Care" means the management of conditions that require prompt attention to relieve pain and/or risk of infection, and to alleviate the burden on hospital emergency departments. Urgent dental care is distinguished from emergency dental care in that urgent dental care requires prompt but not immediate treatment. Examples include dull toothache, mildly swollen gums, or small chips or cracks in teeth.¶

(80) "Veterans Dental Program" is a dental-only enrollment type under the Oregon Health Plan (OHP) as defined in OAR 410-200-0450. ¶

(81) "Young Adults with Special Health Care Needs (YSHCN)" is a benefit eligibility program as defined in OAR 410-200-0455.

Statutory/Other Authority: ORS 413.042, ORS 414.065

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Replace reference to funded services with covered services. Replace reference to covered lines, as all lines on Prioritized List will now be covered. Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-123-1160

Prior Authorization

(1) The Authority covers the following services only with Prior Authorization (PA) approval:¶

(a) Crowns: ¶

(A) Porcelain fused to metal (D2751, D2752); and ¶

(B) Porcelain ceramic (D2740);.¶

(b) Crown repair necessitated by restorative material failure (D2980), covered only for anterior teeth;.¶

(c) Retreatment of previous root canal therapy (D3346), covered only for anterior teeth;.¶

(d) Complete dentures;.¶

(e) Immediate dentures;.¶

(f) Partial dentures;.¶

(g) Immediate partial dentures;.¶

(h) Prefabricated post and core (D2954); ¶

(i) Fixed partial denture repairs (D6980);.¶

(j) Skin graft (D7920);.¶

(k) Comprehensive Orthodontic treatment (D8070, D8080, D8090, D8091);.¶

(l) Hospital dentistry (Refer to OAR 410-123-1490);.¶

(m) Oral surgical services, when performed in an;.¶

(A) Ambulatory surgical center (ASC); or.¶

(B) Outpatient or inpatient hospital setting and related anesthesia (Refer to OAR 410-130-0200); and.¶

(n) Maxillofacial surgeries, in some instances (Refer to OAR 410-130-0200).¶

(2) The Authority does not require PA for outpatient or inpatient services related to a "Dental Emergency Condition" as defined in OAR 410-123-1060:¶

(a) The member's medical record must document any appropriate clinical information that supports the need for the hospitalization; and.¶

(b) Refer to the OHA Prioritized List of Health Services for funded covered emergency dental service codes;.¶

(3) The frequency allowed for the following services may be increased with approved PA;.¶

(a) Frequencies of Periodontal scaling and root planing (D4341, D4342), and scaling in the presence of generalized moderate to severe inflammation (D4346) may be increased from the once (1) every two (2) years limitation when: ¶

(A) Medically necessary and dentally appropriate due to periodontal disease found during pregnancy or 12 months postpartum; and.¶

(B) Documentation in the member's record that supports the need for increased scaling and root planing;.¶

(b) The frequency of Periodontal maintenance (D4910) may be increased from the once (1) in six (6) months limitation when:¶

(A) Medically necessary and dentally appropriate due to periodontal disease found during pregnancy or 12 months postpartum; ¶

(B) Documentation in the member's record documents the need. Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth and clinical attachment loss charting and radiographs; and.¶

(C) Periodontal maintenance is covered only following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three (3) years. ¶

(4) Hospital dentistry always requires PA for the medical services provided by the facility;.¶

(a) If a member is enrolled in a CCO with plan type CCOA;.¶

(A) The dental subcontractor or dental provider is responsible for;.¶

(i) Contacting the CCO for PA requirements and arrangements; and.¶

(ii) Submitting documentation to the CCO associated with the member record;.¶

(B) The CCO must review the documentation and discuss any concerns they have, contacting the dentist as needed; and.¶

(C) The total response time must not exceed seven (7) calendar days from the date of receipt of all required documentation for routine dental care and must follow urgent or emergent dental care timelines;.¶

(b) If a member is enrolled in a CCO with plan type CCOB;.¶

(A) The dentist is responsible for:¶

- (i) Contacting the CCO for PA requirements and arrangements; and,¶
- (ii) Submitting documentation to the CCO associated with the member record.¶

(B) The CCO shall review the documentation and discuss any concerns they have, contacting the dentist as needed. This allows for mutual plan (CCO and FFS) involvement and monitoring; and,¶

(C) The CCO is responsible for payment of all facility and anesthesia services. The FFS program is responsible for payment of all dental services.¶

(c) If a member is enrolled in a CCO with plan type CCOF or CCOG and is enrolled in FFS for physical health:¶

- (A) The dentist is responsible for sending, by secure email or faxing, documentation and a completed American Dental Association (ADA) form to the Authority (Refer to the Dental Services Provider Guide);¶
- (B) The member must have prior approval from the CCO for dental services, and from the Authority for the facility payment;¶
- (C) The Authority is responsible for payment of facility and anesthesia services;¶
- (D) The CCO is responsible for payment of all dental services; and,¶
- (E) The Authority shall issue a decision on PA requests within seven (7) calendar days of date received. ¶

(d) If a member is enrolled in Fee-for-Service for both physical health and dental health or enrolled in the Coordinated Care Organization plan type CCOE, the:¶

- (A) Dental provider is responsible for sending, by secure email or faxing, documentation, and a completed ADA form to the Authority (Refer to the Dental Services Provider Guide); and,¶
- (B) Authority is responsible for payment of all facility, anesthesia services and dental services.¶

(5) How to request PA:¶

- (a) Refer to www.oregon.gov/oha/HSD/OHP/Pages/PA.aspx or the Dental Services Provider Guide for specific instructions and forms to use. PA requests made by telephone or sent through the mail are not accepted;¶
- (b) Submitted documentation must support the medical justification for the service. The PA request must contain:¶

- (A) A cover sheet detailing relevant provider and recipient Medicaid numbers;¶
- (B) Requested date(s) of service;¶
- (C) Healthcare Common Procedure Coding System (HCPCS) or Current Dental Terminology (CDT) Procedure code requested;¶
- (D) Amount of service or units requested; and,¶
- (E) Any additional clinical information supporting medical justification for the services requested.¶

(c) The Authority- recommends inclusion of appropriate digital radiographs with the original PA request submission; and other clinical information that justifies the treatment. Radiographs must be: ¶

- (A)-Correctly identified of diagnostic quality; and,¶
- (B) Clearly labeled with the dental provider's name and address and the member's name.¶

(6) The Authority shall issue a decision on PA requests within seven (7) calendar days upon receipt of the request. The Authority shall provide PA for services when:¶

- (a) The prognosis is favorable, which refers to a:¶

- (A) Prediction that an individual's health condition is likely to improve or lead to a positive outcome; and,¶
- (B) Determination made by a healthcare provider based on medical evidence;¶

- (b) The treatment is practical;¶
- (c) The services are medically necessary and dentally appropriate; and,¶
- (d) A lesser-cost procedure may not achieve the same ultimate results.¶

(7) PA approval does not guarantee member eligibility or reimbursement. It is the responsibility of the provider to check the member's eligibility on each date of service.¶

(8) The Authority may seek a general practice or specialist consultant for:¶

- (a) Professional review to determine if a PA shall be approved; and,¶
- (b) Shall deny PA if the consultant decides that the clinical information furnished does not support the treatment of services.¶

(9) CDT billing codes are in accordance with Current Dental Terminology, © 2025 American Dental Association. All rights reserved.

Statutory/Other Authority: ORS 413.042, ORS 414.065, 414.707

Statutes/Other Implemented: ORS 414.065, 414.707

RULE SUMMARY: Update reference to the OHA Prioritized List. Remove reference to a funding line on the Prioritized List.

CHANGES TO RULE:

410-123-1260

Coverage, Limitations, Exclusions ¶¶

(1) The Oregon Health Authority (Authority) offers ~~/Oregon Health Plan (OHP)/dental/denturist benefits/to OHP Members. The rules included in Chapter 410, Division 123/are specific to/services provided on a/Fee-for-Service (FFS) basis. For/additional/requirements for/Coordinated Care Organization (CCO)/coverage, see Division 141./~~ ¶

(2) Providers of OHP dental/denturist services and items must: ~~/~~ ¶

(a) ~~/Be licensed to practice dentistry and enrolled as a Medicaid provider as required by OAR 410-120-1260;/~~ ¶

(b) ~~/Comply with Chapter 410 Oregon Administrative/Rules (OARs) applicable to their respective scopes of practice./Compliance with applicable Chapter 410 rules does not precede compliance with any other state, local, or federal laws that may/be applicable/to their scopes of practice/and business including, without limitation, licensing by the applicable licensing board of business licenses; and/~~ ¶

(c) ~~/Comply with/Chapter 410,/Division 120/Medical Assistance Program/rules and the/rules included in/Chapter 410, Division 123/Dental/Denturist Services/which/identify/the requirements for/providing/and/submitting/claims for/dental services./~~ ¶

(3) ~~/This rule incorporates/by this reference/the Oregon Health Evidence Review Commission (HERC)HA Prioritized List of Health Services (OHA Prioritized List), through the stated Funding Line (unless otherwise excluded in rule), and/including all line items, diagnostic and treatment codes, guideline notes, statements of intent, coding specifications and annotations (refer to OAR 410-141-3830)/Providers must comply with the Authority rules for dental/services covered by the OHP which include the:/~~ ¶

(a) ~~Funded/Lines on the OHA Prioritized List as defined in OAR 410-141-3830 found at www.oregon.gov/oha/hpa/dsi-herc/pages/prioritized-list.aspx; [web TBD]; and/~~ ¶

(b) ~~/Approved ancillary/procedure/codes/found at data.oregon.gov/Health-Human-Services/Group-6060-Ancillary-Services/fq2m-i6ix/about_data/.~~ ¶

(4) ~~/Information/for/supplemental/guidance only/and/not to be used for/benefit coverage determination/includes the/following:/~~ ¶

(a) ~~/Oregon/Medicaid Dental Services/procedure/code/supplemental/reference at https://data.oregon.gov/Health-Human-Services/Oregon-Medicaid-Dental-Services/495m-gmu2/about_data/;~~ ¶

(b) ~~/Medical-Dental Fee Schedule found on the OHP Fee-for-Service Fee Schedule site at www.oregon.gov/oha/hsd/ohp/pages/fee-schedule.aspx; and/~~ ¶

(c) ~~American Dental Association (ADA)'s/Current Dental Terminology (CDT) code book./The Authority does not cover all codes/in the CDT code book./~~ ¶

(5) ~~/The providers/rendering/services and receiving payment for any of the services/identified/in these Chapter 410, Division 123/rules must make records available for audit, as required by OAR 410-123-1620./~~ ¶

(6) ~~/Providers of OHP/dental/denturist services and items must/comply with/Chapter 410/Oregon Administrative Rules (OARs)/applicable to their respective scopes of practice./Compliance with the applicable Chapter 410/rules does not precede compliance with any other state, local, or federal laws that may/be applicable/to their scopes of practice and businesses including, without limitation, licensing by the applicable licensing board of business licenses./~~ ¶

(7) ~~All coverage limitations and exclusions/for services provided to OHP Members who meet the eligibility criteria for/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/will be determined in accordance with criteria set forth in/Chapter 410, Division 151,/which requires case-by-case review for EPSDT/Medical Necessity and Dental Appropriateness./~~ ¶

(8) ~~Covered dental and oral health services provided in non-dental settings including medical, community and school settings by providers who are medical providers such as physicians and nurses. Criteria and limitations are as follows:/~~ ¶

(a) ~~Dental Screening of a patient (D0190) - including state or federally mandated screenings, are limited observations performed as mass screenings or EPSDT well-child and preventative care visits, to identify individuals who have suspected oral health needs and who must be seen by a dentist for diagnosis. Providers must hold a certificate of completion of the Smiles for Life or First Tooth training; and/~~ ¶

(b) ~~Dental Assessments (D0191) - are limited clinical inspections performed to identify possible signs of oral~~

systemic disease, malformation, or injury, and the potential need for referral diagnosis and treatment. Providers must hold a certificate of completion of the Smile for Life or First Tooth training; ¶

(c) Application of topical fluoride (99128, 99188, D1206, D1208), requires providers to hold a certificate of completion of the Smiles for Life or First Tooth training; ¶

(A) The application of topical fluoride may be delegated by providers to staff, in accordance to their professional boards' scope of practice; ¶

(B) For EPSDT beneficiaries - limited to twice (2) every 12 months; ¶

(C) For non-EPSDT beneficiaries - limited to once (1) every 12 months; ¶

(D) Additional applications may be available, up to a total of four (4) per member within a 12 month period, when high-risk conditions or dental health factors are clearly documented in chart notes for members who: ¶

(i) Have high-risk dental conditions due to disease process, medications, other medical treatments or conditions, or rampant caries; ¶

(ii) Are pregnant or 12 months postpartum; ¶

(iii) Have physical disabilities and cannot perform adequate daily dental health care; ¶

(iv) Have developmental disabilities or other severe cognitive impairment and cannot perform adequate daily dental health care; or ¶

(v) Are under seven (7) years old with high-risk dental health factors, such as poor dental hygiene, deep pits and fissures in teeth, severely crowded teeth, poor diet, etc. ¶

(d) Application of silver diamine fluoride (0792T) by a physician or other healthcare professional is a covered benefit when the member has non-cavitated caries. Providers must hold a certificate of completion of the Smiles for Life or First Tooth training; ¶

(A) For all members - limited to two (2) applications per 12 months; and ¶

(B) Documentation of need must be included on submitted claims. ¶

(9) Diagnostic services (CDT codes D0100 - D0999): ¶

(a) Dental screenings (D0190) and dental assessments (D0191) do not take the place of the need for comprehensive dental evaluations and exams; ¶

(A) For EPSDT beneficiaries - a maximum of twice (2) every 12 months; ¶

(B) For non-EPSDT beneficiaries - a maximum of once (1) every 12 months; ¶

(C) Reimbursable only if an exam (D0120-D0180) is not performed on the same date of service at the same place of service; ¶

(D) The assessment tool used for D0190 and D0191 must be endorsed by the American Dental Association, the American Academy of Pediatric Dentistry, the Association of State and Territorial Dental Directors, or the American Academy of Pediatrics; ¶

(E) Referrals for identified dental needs or for the establishment of a dental home are to be made to the member's primary care dentist for FFS members, or to the member's CCO (or dental subcontractor); and ¶

(F) Anticipatory guidance and counseling on good dental hygiene practices and nutrition is to be provided to the member's caregiver. ¶

(b) The Authority requires dental subcontractors and dental providers to conduct an intake screening of individuals who are enrolled in the Veterans Dental Program within 60 days of the enrolled individual contacting the dental subcontractor or dental provider. This intake screening requires one of the following services being provided, as clinically appropriate: ¶

(A) D0150 - comprehensive oral evaluation of a new or established patient; ¶

(B) D0180 - comprehensive periodontal evaluation of a new or established patient; or ¶

(C) D0120 - periodic oral evaluation of an established patient, if the individual enrolled in the Veterans Dental Program is an established patient. ¶

(c) Caries risk assessment and documentation (D0601, D0602, D0603) are not separately reimbursable but should be documented in the member's chart. ¶

(d) Referrals: ¶

(A) If, during the screening process (periodic or inter-periodic), a dental, medical, substance abuse, or medical condition is discovered, the member must be referred to an appropriate provider for further diagnosis and/or treatment; ¶

(B) The screening provider must explain the need for the referral to the member, member's parent, or guardian; ¶

(C) If the member, member's parent, or guardian agrees to the referral, assistance in finding an appropriate provider and making an appointment shall be offered; and ¶

(D) The member's FFS provider or the CCO shall make available care coordination as needed. ¶

(e) Clinical Dental evaluations (Exams) for: ¶

(A) EPSDT beneficiaries (refer to Division 151): ¶

(i) The Authority covers exams (D0120, D0145, D0150, or D0180) a maximum of twice (2) every 12 months. These codes are not billable if D0191 is billed for the same date of service, at the same place of service. Limitations are as

follows: ¶

(I) D0150: once (1) every 12 months when performed by the same practitioner; ¶

(II) D0180: once (1) every 12 months; and ¶

(ii) The Authority must reimburse D0160 only once (1) every 12 months when performed by the same practitioner. ¶

(B) Non-EPSDT beneficiaries, the Authority covers exams (D0120, D0150, D0160, or D0180) once (1) every 12 months; ¶

(C) For problem-focused exams (urgent or emergent problems), the Authority covers D0140 for the initial exam and D0170 for related problem-focused follow-up exams. D0140 and D0170 are not covered for routine dental visits; ¶

(D) The Authority only covers dental exams performed by medical practitioners when the medical practitioner is an oral surgeon. The surgeon may hold a dual degree, but must bill as an oral surgeon; ¶

(E) The evaluation, diagnosis, and treatment planning components of the exam are the responsibility of the licensed provider. The Authority may not reimburse dental exams when performed by a dental hygienist (with or without an expanded practice permit). ¶

(f) The Authority covers diagnostic imaging as follows: ¶

(A) Intraoral - complete series (D0210) - One (1) time every five (5) years, unless D0330 has been billed within the five (5) year period; ¶

(B) Intraoral - first image (D0220) - One (1) time every 12 months; ¶

(C) Intraoral - additional images (D0230) - Under age six (6), maximum of five (5) times every 12 months. Not to exceed five (5) times on the same date of service for any provider. Radiographs may be billed separately one (1) time every 12 months; ¶

(D) Intraoral - occlusal image (D0240) - One (1) time every 12 months. Not to exceed four (4) times on the same date of services for any provider; ¶

(E) Extraoral images (D0250 and D0251) - One (1) time every 12 months; ¶

(F) Bitewing single image (D0270) - Maximum of two (2) times every 12 months if not billing D0272; ¶

(G) Bitewing two images (D0272) - Under age six (6), maximum of one (1) time every 12 months if not billing D0270 twice; ¶

(H) Bitewing, multiple images (D0273, D0274 and D0277) - One (1) time every 12 months; ¶

(I) Other TMJ images (D0321) - By Report; ¶

(J) Dental tomographic survey (D0322) - One (1) time every 12 months; ¶

(K) Panoramic image (D0330) - One (1) time every five (5) years, unless D0210 has been billed within the five (5) year period; ¶

(L) Cone beam CT capture (D0364, D0365, D0366, D0367) - Only when performed as part of the pre-orthodontic treatment examination; and ¶

(M) 3d print of 3d surface scan (D0396). ¶

(g) The Authority covers panoramic radiographic image (D0330) or intra-oral complete series (D0210) once (1) every five (5) years, but both cannot be done within the five (5) year period; ¶

(h) Members must be a minimum of six (6) years old for billing intra-oral complete series. The minimum standards for reimbursement of intra-oral complete series are: ¶

(A) For members age six (6) through 11 a minimum of 10 periapical and two (2) bitewings for a total of 12 films; and ¶

(B) For members ages 12 and older a minimum of 10 periapical and four (4) bitewings for a total of 14 films. ¶

(i) If fees for multiple single radiographs exceed the allowable reimbursement for an intraoral-complete series (full mouth), the Authority must reimburse for the complete series; ¶

(j) Additional films are covered if medically necessary and dentally appropriate (e.g., fractures); ¶

(k) If the Authority determines the number of radiographs to be excessive, payment for some or all radiographs of the same tooth or area shall be denied; ¶

(l) The exception to these limitations is if the member is new to the office or clinic and the office or clinic is unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records must be included in the member's records; and ¶

(m) Digital radiographs, if printed, must be on photo paper to assure sufficient diagnostic quality of images. ¶

(10) Preventative Services (CDT codes D1000-D1999): ¶

(a) Topical application of fluoride-(D1206, D1208, 99128, 99188): ¶

(A) For EPSDT beneficiaries, limited to twice (2) every 12 months; ¶

(B) For non-EPSDT beneficiaries, limited to once (1) every 12 months; ¶

(C) Additional topical fluoride treatments are available, up to a total of four (4) treatments per member within a 12 month period, when high-risk conditions or dental health factors are clearly documented by D0603 in chart notes for members who: ¶

- (i) Have high-risk dental conditions due to disease process, medications, other medical treatments or conditions, or rampant caries; ¶
- (ii) Are pregnant or 12 months postpartum; ¶
- (iii) Have physical disabilities and cannot perform adequate daily dental health care; ¶
- (iv) Have developmental disabilities or other severe cognitive impairment and cannot perform adequate daily dental health care; or ¶
- (v) Are under seven (7) years old with high-risk dental health factors, such as poor dental hygiene, deep pits, and fissures in teeth, severely crowded teeth, poor diet, etc. ¶
- (D) Fluoride limits include any combination of fluoride varnish or other topical fluoride. ¶
- (b) Dental sealants (D1351) are covered for EPSDT beneficiaries as follows: ¶
- (A) Members age 16 and older require PA; ¶
- (B) Only permanent molars (additional teeth require PA); ¶
- (C) Only one (1) sealant treatment per tooth every five (5) years, except when visible evidence of clinical failure; and ¶
- (D) The original provider is responsible for any repair or replacement during the 36-month period of initial sealant placement. ¶
- (c) Dental prophylaxis (D1110, D1120) are not covered by the Authority if provided on the same date of service as D4355, D4346 or D4910. Coverage is as follows: ¶
- (A) EPSDT beneficiaries, limited to twice (2) per 12 months; ¶
- (B) Non-EPSDT beneficiaries, limited to once (1) per 12 months; and ¶
- (C) Additional prophylaxis benefit provisions are available for persons with high-risk dental conditions due to disease process, pregnancy, medications, or other medical treatments or conditions, severe periodontal disease, rampant caries and for persons with disabilities who cannot perform adequate daily dental health care. ¶
- (d) Silver diamine fluoride (SDF) application (D1354, D1355): ¶
- (A) Is covered for all members; ¶
- (B) The Authority reimburses per application, not per tooth; ¶
- (C) Is limited to two (2) applications per year. Additional applications for EPSDT beneficiaries is allowable with approved PA; ¶
- (D) Requires that the tooth or teeth numbers be included on the claim; ¶
- (E) Use D1354 when SDF is applied for the treatment (rather than prevention) of caries. The treated tooth or teeth must be; ¶
- (i) Covered with topical application of fluoride; or ¶
- (ii) Covered with an interim direct restoration (D2940) or a permanent restoration when medically necessary and dentally appropriate. ¶
- (F) When SDF is applied for the treatment of caries by a non-dental professional (0792T), refer to the guidance in the earlier section of this rule. Coverage is limited to two (2) applications per year. ¶
- (e) Immunization counseling (D1301) is covered as described in 410-123-1262. ¶
- (f) The Authority covers Tobacco counseling for the control and prevention of oral disease (D1320) for services provided during a dental visit, when using the Five-A approach outlined below, limited to a maximum of 10 services within a three (3) month period, when the following is provided: ¶
- (A) ASK: Identify the member's tobacco-use status at each visit and record information in the chart; ¶
- (B) ADVISE: Using a strong personalized message, advise members on their dental health conditions related to tobacco use and give direct advice to quit using tobacco and seek help; ¶
- (C) ASSESS: Refer member to external resources or internal counseling and intervention protocol if the tobacco user is willing to make a quit attempt; ¶
- (D) ASSIST: Provide counseling and pharmacotherapy to help member quit tobacco, if dental provider chooses to assist; and ¶
- (E) ARRANGE: Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date if dental provider chooses to arrange. ¶
- (g) The Authority covers Nutritional counseling (D1310) and Counseling for high risk substance use (D1321) for services provided during a dental visit using the Five-A approach outlined below. Each of these services is limited to two (2) services within a 12 month period, when the following is provided: ¶
- (A) ASK: Identify the member's behavior; ¶
- (B) ADVISE: Urge the member to change behavior; ¶
- (C) ASSESS: Determine the member's willingness to make change; ¶
- (D) ASSIST: Help the member with a plan and resources, if dental provider chooses; and ¶
- (E) ARRANGE: Schedule follow-up support, if dental provider chooses. ¶
- (h) Space maintenance (passive appliances) are: ¶
- (A) Covered for EPSDT beneficiaries; and ¶

(B) Not replaceable when lost or damaged. ¶

(11) The Authority's coverage limitations of restorative, periodontic, and prosthetic treatments include the following: ¶

(a) Documentation must be included in the member's charts to support the treatment; ¶

(b) Treatments must be consistent with the prevailing standard of care and may be limited as follows, when: ¶

(A) Prognosis is unfavorable; ¶

(B) Treatment is impractical; ¶

(C) A lesser cost procedure achieves the same ultimate result; or ¶

(D) The treatment has specific limitations outlines in this rule. ¶

(c) Periodontal health needs to be stable and supportive of a prosthetic. -/Prosthetic treatment, including porcelain fused to metal crowns and porcelain/ceramic crowns are limited until documented by examination; ¶

(A) Rampant caries is arrested; and ¶

(B) A period of adequate dental hygiene and periodontal stability is demonstrated. ¶

(12) Restorative Services (CDT codes D2000-D2999): ¶

(a) Amalgam and resin-based composite restorations, direct: ¶

(A) Resin-based composite crowns on anterior teeth (D2390) are only covered for EPSDT beneficiaries, and members who are pregnant; ¶

(B) The Authority reimburses posterior composite restorations at the same rate as amalgam restorations; ¶

(C) The Authority limits payment of posterior composite restorations to once (1) every five (5) years, per tooth; ¶

(D) The Authority limits payment of covered restorations to the maximum restoration fee of four (4) surfaces per tooth. Refer to the ADA CDT codebook for definitions of restorative procedures; ¶

(E) Providers must combine and bill multiple surface restorations as one line per tooth using the appropriate code. Providers may not bill multiple surface restorations performed on a single tooth on the same day on separate lines. For example, if tooth #30 has a buccal amalgam and a mesial-occlusal-distal (MOD) amalgam, then bill MOD, B, using code D2161 (four (4) or more surfaces); ¶

(F) The Authority shall not reimburse for an amalgam or composite restoration and a crown on the same tooth; ¶

(G) Interim direct restorations (D2940) on primary dentition are covered to restore and prevent progression of dental caries. They are not definitive restorations and are not to be used as a base or liner under a restoration; ¶

(H) Reattachment of tooth fragment is covered once in the lifetime of a tooth when there is no pulp exposure and no need for endodontic treatment; ¶

(I) The Authority reimburses for a surface not more than once (1) in each treatment episode regardless of the number or combination of restorations; and ¶

(J) The restoration fee includes payment for occlusal adjustment and polishing of the restoration. ¶

(b) Indirect crowns and related services: ¶

(A) The fee for the crown includes payment for preparation of the gingival tissue; ¶

(B) The Authority covers crowns only when there is significant loss of clinical crown, no other restorations restore function, the crown-to-root ratio is 50:50 or better, and the tooth is restorable to function without other surgical procedures. Endodontic therapy alone (with or without a post) is not a consideration, nor are aesthetics; ¶

(C) The Authority covers core buildup only when: ¶

(i) Necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture; ¶

(ii) Done in conjunction with a crown; and ¶

(iii) More than 50 percent of the tooth structure is remaining for coverage of the core buildup. ¶

(D) Reimbursement of retention pins is per tooth, not per pin; ¶

(E) Payment shall be made only upon final cementation; ¶

(F) Partial payment will not be made for an undelivered crown; ¶

(G) Prefabricated stainless steel crowns are allowed only for anterior primary teeth and posterior permanent or primary teeth; ¶

(H) The Authority covers the following only for EPSDT beneficiaries, and for members who are pregnant: ¶

(i) Prefabricated resin crowns for anterior teeth, permanent or primary; ¶

(ii) Prefabricated resin crowns for posterior teeth, permanent or primary, once (1) per tooth in a five (5) year period; ¶

(iii) Prefabricated stainless-steel crowns with resin window are allowed only for anterior teeth, permanent or primary; ¶

(iv) Prefabricated post and core in addition to crowns; ¶

(v) Crowns (resin-based composite - D2710 and D2712, porcelain fused to metal (PFM) - D2751 and D2752, and porcelain ceramic - D2740 as follows: ¶

(I) Limited to teeth numbers 6-11, 22, and 27 only, if dentally appropriate; ¶

(II) Limited to four (4) in a seven (7) year period. This limitation includes any replacement crowns allowed; and ¶

(III) Rampant caries are arrested, and the member demonstrates a period of adequate dental hygiene before

prosthetics are proposed.

(vi) Porcelain fused to metal crowns (D2751, D2752), and porcelain ceramic crowns (D2740) must meet the following additional criteria:

(I) The Dental Practitioner has attempted all other dentally appropriate restoration options and documented failure of those options;

(II) Written documentation in the member's chart indicates that PFM is the only restoration option that restores function;

(III) The Dental Practitioner submits radiographs to the Authority for review. History, diagnosis, and treatment plan may be requested;

(IV) The member has documented stable periodontal status with clinical attachment loss within 1-3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeters and over, documentation must be maintained in the member's chart of the dentist's findings supporting stability and why the increased pocket depths shall not adversely affect expected long-term prognosis;

(V) The crown has a favorable long-term prognosis; and

(VI) If the tooth to be crowned is a clasp/abutment tooth in partial denture, both prognosis for the crown itself and the tooth's contribution to partial denture must have favorable expected long-term prognosis.

(I) Crown replacement coverage is as follows:

(i) D2710, D2712, D2740, D2751, D2752 are limited to once (1) every seven (7) years;

(ii) All other covered crowns are limited to once (1) every five (5) years; and

(iii) Exceptions to the above limitations due to acute trauma are based on the following factors:

(I) Extent of crown damage;

(II) Extent of damage to other teeth or crowns;

(III) Extent of impaired mastication;

(IV) Tooth is restorable without other surgical procedures; and

(V) If loss of tooth may result in coverage of removable prosthetic.

(J) Crown repair requires PA and is limited to anterior teeth.

(13) Endodontic Services (CDT codes D3000-D3999):

(a) All radiographic images taken during the course of root canal therapy and all post-treatment radiographic images are included in the fee for the root canal procedure. At least one (1) pre-treatment radiographic image demonstrating the need for the procedure, and one (1) post-treatment radiographic images that demonstrates the result of the treatment, must be maintained in the member's record;

(b) The Authority covers endodontic therapy as follows only when the crown-to-root ratio is 50:50 or better and if the tooth is restorable to function with direct or indirect restoration without other surgical procedures:

(A) For EPSDT beneficiaries: all primary teeth, permanent anterior teeth, premolars, first molars and second molars;

(B) For members who are pregnant or 12 months postpartum: permanent anterior teeth, premolars, and first molars; and

(C) For non-pregnant adults: anterior teeth and premolars.

(c) Endodontic retreatment and apicoectomy:

(A) The Authority does not cover retreatment of a previous root canal or apicoectomy for premolars or molars;

(B) The Authority limits either a retreatment or an apicoectomy (but not both procedures for the same tooth) to symptomatic anterior teeth when:

(i) Crown-to-root ratio is 50:50 or better;

(ii) The tooth is restorable without other surgical procedures; or

(iii) If loss of tooth shall result in the need for removable prosthodontics.

(C) Retrograde filling is covered only when done in conjunction with a covered apicoectomy of an anterior tooth.

(d) The Authority does not allow separate reimbursement for open-and-drain as a palliative procedure when the root canal is completed on the same date of service or if the same practitioner or Dental Practitioner in the same group practice completed the procedure;

(e) Apexification/recalcification procedures:

(A) The Authority limits payment for apexification to permanent teeth only;

(B) D3351-D3353 are limited to once (1) per tooth; and

(C) Covered only for EPSDT beneficiaries, or members who are pregnant or 12 months postpartum.

(14) Periodontic Services (CDT codes D4000-D4999):

(a) The Authority does not reimburse the following codes if performed on the same date of service D1110, D1120, D4210, D4211, D4341, D4346, D4355, and D4910.

(b) Surgical periodontal services:

(A) Gingivectomy/Gingivoplasty (D4210, D4211) coverage is limited to severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to dental hygiene procedures (e.g., Dilantin hyperplasia),

and includes six (6) months routine postoperative care; and ¶

(B) Gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212) is considered part of the restoration and is not separately billable. ¶

(c) Non-surgical periodontal services: ¶

(A) Periodontal scaling and root planing (D4341, D4342) is allowed once (1) every two (2) years; ¶

(i) A maximum of two (2) quadrants on one date of service is payable, except in extraordinary circumstances supported by documentation; ¶

(ii) Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets of 5 mm or greater; ¶

(B) Single implants may count as an additional tooth when billing, the maximum number per quadrant and pocket depth requirements still apply; ¶

(C) Full mouth debridement (D4355) allowed once (1) every two (2) years; and ¶

(D) Scaling in the presence of generalized moderate or severe gingival inflammation, full mouth, after dental evaluation (D4346) is allowed once (1) every two (2) years. ¶

(d) Periodontal maintenance (D4910) is allowed once (1) every six (6) months; ¶

(A) Following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three (3) years; and ¶

(B) Additional periodontal maintenance requires PA and may be requested when: ¶

(i) Medically necessary and dentally appropriate, including situations involving periodontal disease during pregnancy; and ¶

(ii) The member's medical record is submitted and supports the need for increased periodontal maintenance (chart notes, pocket depths and radiographs). ¶

(e) Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and radiographs; ¶

(15) Prosthodontics, Removable (CDT codes D5000-D5899): ¶

(a) The Authority covers complete dentures once (1) every 10 years, only if medically necessary and dentally appropriate, with PA approval; ¶

(A) Coverage is for only one of the following options (not both); ¶

(i) Complete dentures (D5110, D5120); or ¶

(ii) Immediate dentures (D5130, D5140); ¶

(B) The Authority's 10-year coverage limitation for complete dentures applies regardless of the member's OHP or CCO enrollment status at the time the member received the denture; and ¶

(C) The member's periodontal health needs to be stable and supportive of a prosthetic. ¶

(b) The fee for the denture includes payment for adjustments during the six (6) month period following the delivery of the denture. Adjustments and repairs needed beyond six (6) months from the delivery of the denture are covered by the Authority as follows: ¶

(A) A maximum of four (4) times per year for: ¶

(i) Adjustments to dentures, per arch (D5410, D5411); ¶

(ii) Replacement of missing or broken teeth, each tooth (D5520); and ¶

(B) A maximum of two (2) times per year for broken complete denture base (D5511, D5512). ¶

(c) The Authority covers partial dentures once (1) every five (5) years, only if medically necessary and dentally appropriate, with PA approval; ¶

(A) Coverage is for only one of the following options: ¶

(i) Partial denture resin base (D5211, D5212); ¶

(ii) Immediate partial denture (D5221, D5222) or ¶

(iii) Interim partial dentures (D5820, D5821); ¶

(B) The Authority's five (5) year coverage limitation for partial dentures applies regardless of the member's OHP or CCO enrollment status at the time the member's last partial was received; ¶

(C) Periodontal health needs to be stable and supportive of a prosthetic; ¶

(D) Interim partial dentures (also referred to as "flippers") are covered only if the member has one (1) or more anterior teeth missing; ¶

(E) Partial dentures and immediate partial dentures are covered as follows: ¶

(i) For EPSDT members: The member must have one (1) or more anterior teeth missing or four (4) or more missing posterior teeth per arch with resulting space equivalent to the loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth; ¶

(ii) For non-EPSDT members: The member must have one (1) or more missing anterior teeth or six (6) or more missing posterior teeth per arch with documentation by the provider of resulting space causing serious impairment to mastication. ¶ Third molars are not a consideration when counting missing teeth; ¶

(F) The Practitioner must note the teeth to be replaced and the teeth to be clasped with requesting PA; ¶

- (G) The Authority does not approve resin partial dentures (D5211, D5212) if stainless steel crowns are used as abutments; and.¶
- (H) Partial dentures are not to be used in lieu of space maintainers. //¶
- (d) The fee for the partial denture includes payment for adjustments during the six (6) month period following delivery. Adjustments and repairs needed beyond six (6) months after delivery of the partial denture as follows:¶
- (A) A maximum of four (4) times per year for:¶
- (i) Adjustments to partial dentures, per arch (D5421, D5422);¶
 - (ii) Replace broken tooth on a partial denture, each tooth (D5640);¶
 - (iii) Add tooth to existing partial denture (D5650);¶
- (B) A maximum of two (2) times per year for:¶
- (i) Repair resin partial denture base (D5611, D5612);¶
 - (ii) Repair cast partial framework (D5621, D5622); ¶
 - (iii) Repair or replace broken retentive/clasping materials, per tooth (D5630); and.¶
 - (iv) Add clasp to existing partial denture, per tooth (D5660);¶
- (C) Replacement of all partial denture teeth and acrylic on cast metal framework (D5670, D5671), with PA approval;¶
- (i) A maximum of once (1) per five (5) years per arch;¶
 - (ii) When five (5) or more years have passed since the partial denture was originally delivered; and.¶
 - (iii) Is considered replacement of the partial denture so a new denture shall not be reimbursed for another five (5) years.¶
- (e) For denture reimbursement;¶
- (A) The member must have active coverage on the date of the final impression;¶
 - (B) The dentures must be delivered within 45 days of the date of the final impression; and.¶
 - (C) The claim includes both the date of the final impression and the date of delivery. If the member loses OHP coverage during the time that the denture is being fabricated, submit the claim using the date of the final impression.¶
- (f) The Authority may cover reasonable and necessary replacement of medically necessary and dentally appropriate covered dentures, including those purchased or in used before the member enrolled with OHP;¶
- (g) Replacement of dentures is covered involving the provision of the medically necessary and dentally appropriate item when:¶
- (A) The item cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement);¶
 - (B) The loss of the item is due to circumstance beyond the member's control (e.g., irreparable damage referring to a specific accident, natural disaster, or situation); ¶
 - (C) There is a change in the member's condition that warrants a new item (e.g., cases of acute trauma, catastrophic illness that directly or indirectly affects the dental condition and results in additional tooth loss). This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for conditions mentioned earlier; and ¶
 - (D) There is coverage for the specific item as identified in Chapter 410, Division 123.¶
- (h) The Authority may not cover replacement of dentures:¶
- (A) When cases suggest malicious damage, culpable neglect, or wrongful disposition of the denture; or ¶
 - (B) In the presence of untreated severe periodontal disease.¶
- (i) Replacement of a partial denture with a complete denture is payable five (5) years after the partial denture placement; ¶
- (j) The Authority covers denture rebase procedures (D5710, D5711, D5720, D5721) as follows, only if a reline does not adequately solve the problem:¶
- (A) For EPSDT members: once (1) every three (3) years;¶
 - (B) For non-EPSDT members: once (1) every five (5) years when there is documentation of a current, failed reline procedure;¶
 - (C) Exceptions to these limitations may be considered by the Authority for conditions as listed for warranting replacement of partial and complete dentures; and.¶
 - (D) Untreated severe periodontal disease may not warrant rebase procedures.¶
- (k) The Authority covers denture reline (direct) procedures (D5730, D5731, D5740, D5741) as follows: ¶
- (A) For EPSDT members: once (1) every three (3) years;¶
 - (B) For non-EPSDT members: once (1) every five (5) years;¶
 - (C) A new or replacement complete or partial denture(s) on the same arch are not reimbursable for 12 months after the reline; and.¶
 - (D) Exceptions to these limitations may be considered by the Authority for conditions as listed for warranting replacement of partial and complete dentures.¶

- (l) The Authority covers denture reline (indirect) laboratory procedures (D5750, D5751, D5760, D5761) six (6) months after placement of any denture as follows:
 - (A) For EPSDT members: once (1) every three (3) years;
 - (B) For non-EPSDT members: once (1) every five (5) years;
 - (C) A new or replacement denture on the same arch is not reimbursable for 12 months after the reline; and
 - (D) Exceptions to these limitations may be considered by the Authority for conditions as listed for warranting replacement of partial and complete dentures.
- (m) The Authority covers tissue conditioning (D5850, D5851) for all members once:
 - (A) Per denture unit in conjunction with immediate dentures; and
 - (B) Prior to new denture placement.
- (16) Maxillofacial Prosthetic Services (CDT codes D5900-D5999):
 - (a) Fluoride gel carrier is limited to those members whose severity of dental disease causes the increased cleaning and fluoride treatments allowed in rule to be insufficient. The Dental Practitioner must document failure of those options prior to use of the fluoride gel carrier; and
 - (b) All other maxillofacial prosthetics are medical services;
 - (A) Bill for medical maxillofacial prosthetics using the professional (CMS1500, DMAP 505, 837D or 837P) claim format;
 - (B) For members receiving services through a CCO, bill medical maxillofacial prosthetics to the CCO; and
 - (C) For members receiving medical services through FFS, bill the Authority.
- (17) Prosthodontics, Fixed (CDT codes D6200-D6999): Surgical removal of implant body (D6100) and Removal of implant body (D6105) are covered for all members, per Guideline Note 123, when there is:
 - (a) Advanced peri-implantitis with bone loss and mobility, abscess; or
 - (b) Implant fracture.
- (18) Oral & Maxillofacial Surgery (D7000-D7999): Billing Procedures:
 - (a) Bill on a dental claim form using CDT codes for procedures that are directly related to the teeth and the structures directly supporting teeth;
 - (b) The Medical/Surgical Program is responsible for all dental health procedures performed due to an underlying medical condition (i.e., procedures on or in preparation for treatment of the jaw, tongue, roof of mouth). Such procedures must be billed using ICD-10, HCPCS and CPT billing codes using the professional (CMS1500, DMAP 505 or 837P) claim format;
 - (c) The following services are covered based on severity and included situations deemed to cause gingival recession or movement of the gingival margin when frenum is placed under tension:
 - (A) Buccal/labial frenectomy (frenulectomy) (D7961), refer to Guideline Note 48;
 - (i) Maxillary labial frenulectomy is not covered until age 12; and
 - (ii) Not billable if member has received D7963;
 - (B) Lingual frenectomy (frenulectomy) (D7962), refer to Guideline Note 48 and 139, is not covered until age 12 unless ankyloglossia is interfering with breastfeeding; or
 - (C) Frenuloplasty (D7963), refer to Guideline Note 48;
 - (i) Once (1) per lifetime per quadrant; and
 - (ii) Not billable if member has received D7961.
 - (d) Emergency tracheotomy (D7990) is an ancillary code reimbursable for all members;
 - (e) All ancillary and diagnosis codes must be used for services that are medically necessary and dentally appropriate; and
 - (f) Alveoloplasty not in conjunction with extractions (D7320, D7321) is reimbursable for EPSDT beneficiaries, and for members who are pregnant or 12 months postpartum.
- (19) Orthodontics (CDT Codes D8000-D8999):
 - (a) The Authority covers orthodontia services and extractions to treat cleft palate with airway obstruction, cleft palate and/or cleft lip, or deformities of the head, and handicapping malocclusions (HM), not for cosmetic purposes, when:
 - (A) The member has a craniofacial anomaly health condition that is included on ~~a covered line of the~~ the OHA Prioritized List of Health Services;
 - (B) The Authority approves the PA request for orthodontic treatment; and
 - (C) EPSDT qualification for the OHP Orthodontic benefit is determined when:
 - (i) Dental Appropriateness as demonstrated when the member has a malocclusion; and
 - (ii) Medical Necessity for the orthodontic treatment is demonstrated when the member meets the automatic qualifying criteria and/or a score of 26 or higher on the Handicapping Labiolingual Deviation (HLD) score index.
 - (b) Pre-orthodontic treatment examinations (D8660) must be provided by a licensed dentist.
 - (c) Pre-orthodontic treatment examinations (D8660) do not require PA. Coverage is for members whose clinical presentation and preliminary comprehensive or periodic exam findings strongly suggest that they may qualify for

orthodontic treatment under HM criteria, as established by the Authority. The imaging required for evaluation is not to be billed separately. Coverage is:¶

(A) Once (1) per member, per provider, in a 12 month period (not on the same day as another routine or general dental evaluation or examination); and.¶

(B) When submitted alongside the following documentation to justify the need for treatment:¶

(i) The Authority-approved HLD Index California Modified Scoring Form (completed, scored, and signed);.¶

(ii) Intra-oral and extra-oral photographs of diagnostic quality, adhering to American Association of Orthodontists (AAO) standards, capturing key aspects of the malocclusion;.¶

(iii) Panoramic radiographs or cephalometric images including tracings that document skeletal and dental relationships crucial for evaluating the severity of malocclusion; and.¶

(iv) A comprehensive narrative of medical necessity, explicitly stating how the malocclusion significantly impacts the member's oral health, airway, or overall functional capacity.¶

(d) PA approval for comprehensive orthodontic treatment (D8070, D8080, D8090, D8091), must meet the criteria in Guideline Note 169 of the OHA Prioritized List of Health Service.¶

(e) Comprehensive orthodontic treatment must be completed by a licensed dentist who has:¶

(A) Completed a Commission of Dental Accreditation (CODA) orthodontic fellowship or residency program;.¶

(B) Certified additional orthodontic training, a minimum of 30 hours of orthodontic continuing education (CE) in the past three (3) years that was approved by the American Dental Association Continuing Education Recognition Program (ADA CERP); or.¶

(C) Completed five (5) comprehensive orthodontic treatment cases in the past three (3) years, verified by case logs and patient outcomes.¶

(f) Orthodontic treatment must begin while the member is an EPSDT beneficiary, or immediately after, if surgical corrections that were started during the member's EPSDT beneficiary period for covered conditions were not completed during that period.¶

(g) Payment for comprehensive orthodontic treatment includes all appliances, repairs, and all follow-up visits.¶

(h) The Authority pays for orthodontia in one (1) lump sum upon beginning of treatment;.¶

(A) If the member transfers to another orthodontist during treatment, or treatment is terminated, the Authority shall recover the overpayment (refer to OAR 410-120-1397) based on the length of the treatment plan from the first date of service (DOS); and ¶

(B) Providers may discontinue orthodontic treatment of a member in cases including poor dental hygiene, continued missed appointments, or if treatment is a detriment to the member.¶

(i) Licensed dentists providing orthodontic treatment may:¶

(A) Submit PA requests for the extractions and/or bond surgeries that are documented as needed in the member's orthodontic treatment plan; and.¶

(B) Refer members to enrolled specialists for extractions and/or bond surgeries when such services are beyond the scope of the member's primary care dentist. ¶

(j) As long as the orthodontist continues treatment, the Authority may not require a refund even though the member may become ineligible for medical assistance sometime during the treatment period.¶

(k) Care navigation assistance for members must be made available during transfer of care in situations such as provider changes.¶

(20) Adjunctive General and Other Services (CDT codes D9000-D9999):.¶

(a) Fixed partial denture sectioning (D9120) is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment;.¶

(b) Anesthesia and sedation:¶

(A) The Authority reimburses administration of general anesthesia or IV sedation only for those members with concurrent needs: age; physical, medical, or mental status; or degree of difficulty of the procedure; and.¶

(B) The Authority reimburses providers with a current permit to administer General Anesthesia or IV Sedation as follows:¶

(i) For each 15-minute period, up to two and a half hours on the same day of service in a dental office setting, and up to three and a half hours on the same day of service in a hospital setting and ASC;.¶

(ii) Each 15-minute period represents a quantity of one (1). Enter this number in the quantity column.¶

(C) The Authority reimburses administration of Nitrous Oxide per date of service, not by time;.¶

(D) Enteral and Non-intravenous parenteral conscious sedation with or without coadministration of Nitrous Oxide are covered only for EPSDT beneficiaries as follows:¶

(i) Members age 13 and older require PA;.¶

(ii) Limited to four (4) times per year; and.¶

(iii) Includes payment for monitoring and Nitrous Oxide;.¶

(E) Upon request, providers must submit a copy of their permit to administer Anesthesia, Analgesia, and Sedation

to the Authority; and.¶

(F) The Authority covers CPT 00170 (anesthesia services during procedures on the mouth). When billing for services provided in conjunction with dental treatments—in the office setting, use the professional claim format using an appropriate non-facility Place of Service code.¶

(c) House/extended care facility call (D9410) is limited to urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider's or facility's convenience.¶

(21) Sleep Apnea Services:¶

(a) Sleep apnea devices and appliances may be placed or fabricated by a general dentist or specialist although they are considered medical services;¶

(b) Bill for sleep apnea services using medical billing codes on the professional claim form unless guidance specifies otherwise;¶

(c) Custom sleep apnea appliance fabrication and placement (D9947) must be billed on a dental claim form (see ~~HERC~~ Guideline Notes 27 and 36 for criteria), and is replaceable at the end of the five (5) year reasonable useful lifetime;¶

(d) The Authority does not cover adjustments for dental sleep apnea appliances. The adjustments are considered part of the normal follow-up care within the first 90 days after provision of the device, and are included as services of (D9947); and.¶

(e) Dental sleep apnea repairs (D9949) are covered when necessary and appropriate to make item serviceable. If the expense for repairs exceeds the estimated expense of purchasing another item, no payment must be made for the excess.¶

(22) Dental care access standards for pregnant members:¶

(a) Dental care benefits for pregnant members shall continue for 12 months following the end of pregnancy; and.¶

(b) For additional dental care benefit for members who are pregnant or 12 months postpartum, refer to OAR 410-123-1510.¶

(23) Services considered incidental, integral to the primary service rendered, part of another service, or included in routine post-op or follow-up care are not eligible for separate reimbursement.¶

(a) Participating providers may not balance bill members for these services;¶

(b) Not all services included in the Current Dental Terminology (CDT) codebook are covered by the Authority; ¶

(c) These services must not be listed as combined with another procedure; and.¶

(d) Under the Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services (CMS) issued regulations in 2024 for payment for dental services that are inextricably linked to certain covered medical services, such as dental exams and necessary treatments prior to organ transplants, cardiac valve replacements, valvuloplasty procedures, and treatments for head and neck cancers. Such services should be billed directly to Medicare.¶

(24) The following services are not eligible for separate reimbursement:¶

(a) Alveolectomy/Alveoloplasty in conjunction with extractions;¶

(b) Cardiac and other monitoring;¶

(c) Caries risk assessment and documentation (D0601-D0603);¶

(d) Curettage and root planing - per tooth is not eligible for separate reimbursement unless the service is significant and separately identifiable;¶

(e) Diagnostic casts (D0470);¶

(f) Direct pulp cap (D3110);¶

(g) Discing;¶

(h) Dressing change;¶

(i) Electrosurgery;¶

(j) Equilibration;¶

(k) Gingival curettage - per tooth (D4220);¶

(l) Gingival irrigation (D4921);¶

(m) Gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212);¶

(n) Indirect pulp cap (D3120);¶

(o) Local anesthesia;¶

(p) Medicated pulp chambers;¶

(q) Occlusal adjustments (D9951, D9952);¶

(r) Occlusal analysis;¶

(s) Odontoplasty;¶

(t) Oral hygiene instruction (D1330);¶

(u) Periodontal charting, probing;¶

(v) Post removal;¶

(w) Polishing fillings;¶

(x) Post extraction treatment for alveolaritis (dry socket treatment) if done by the provider of the extraction;¶

(y) Pulp vitality tests (D0460);¶

(z) Smooth broken tooth;¶

(aa) Special infection control procedures;¶

(bb) Surgical procedure for isolation of tooth with rubber dam (D3910);¶

(cc) Surgical splint (D5988);¶

(dd) Surgical stent (D5982);¶

(ee) Suture removal; ¶

(ff) Testing for cracked tooth (D0461); and¶

(gg) Teledentistry (D9995, D9996).¶

(25) The following general categories of dental services are not covered for any member, unless coverage is specified or member is an EPSDT beneficiary and meets requirements of OAR Chapter 410, Division 151, as several of these services are considered elective or "cosmetic" in nature (i.e., done for the sake of appearance):¶

(a) Desensitization;¶

(b) Implant and implant services (See OHA Prioritized List Guideline Notes 123 and 169);¶

(c) Mastique or veneer procedure;¶

(d) Orthodontic treatment;¶

(e) Overhang removal;¶

(f) Procedures, appliances, or restorations solely for aesthetic or cosmetic purposes;¶

(g) Temporomandibular joint (TMJ) dysfunction treatment; and¶

(h) Tooth bleaching.¶

(26) Current Dental Terminology, © 2025 American Dental Association. All rights reserved.
 Statutory/Other Authority: ORS 413.042, ORS 414.065
 Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1620

RULE SUMMARY: Remove reference to a funding line on the Prioritized List. Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-123-1620

Coding and Documentation

(1) Providers must use the standardized code sets adopted by the Health Insurance Portability and Accountability Act (HIPAA) and the Centers for Medicare and Medicaid Services (CMS), and by the Chapter 410 Division 120 rules.¶

(2) Unless otherwise directed in this Chapter 410, Division 123 rule, providers must accurately code claims according to the national standards in effect for the date the service(s) was provided. National Code Set issuance alone may not be construed as coverage or a covered service by the Authority.¶

(3) The Authority or designee may review or audit providers' claims before or after payment in accordance with OARs 410-120-1396, 410-120-1395, or 410-120-1397 and payments may be denied or subject to recovery if the review or audit determines the care, service or item;¶

(a) Was not provided in accordance with this Chapter 410 Division 123, or Chapter 410 Division 120 rules; or ¶

(b) Does not meet the criteria for quality or appropriateness of payment.¶

(4) Procedure codes:¶

(a) For dental services, and procedures that are directly related to the teeth and the structures supporting the teeth, use Current Dental Terminology (CDT) codes as maintained and distributed by the American Dental Association (ADA). Contact the ADA to obtain a current copy of the CDT reference manual;¶

(b) For physician provided oral health services performed due to an underlying medical condition (i.e., procedures on or in preparation for treatment of the jaw, tongue, cheek, roof of mouth), use Health Care Common Procedure Coding System (HCCPS) and Current Procedural Terminology (CPT) codes; and¶

(c) For procedures covered under the Authority's medical surgical program, refer to Chapter 410, Division 130.¶

(5) International Classification of Diseases 10th Clinical Modification (ICD-10-CM) diagnosis codes are:¶

(a) Not required for dental services submitted on an ADA claim form; and¶

(b) Are required for medical surgical program services submitted on a professional claim form (refer to Chapter 410, Division 130).¶

(6) Ancillary services must be medically necessary and dentally appropriate:¶

(a) For medication and deep sedation provided in hospitalization, conditions must be ~~above the funding line of~~ on the OHA Prioritized List and are subject to the Prioritized List's ancillary guideline notes;¶

(b) Some ancillary codes are not eligible for separate reimbursement (Refer to OAR 410-123-1260); and¶

(c) Ancillary codes covered by Medicaid are listed in Code Group 6060 and can be found by referencing data.oregon.gov/Health-Human-Services/Group-6060-Ancillary-Services/fq2m-i6ix/about_data.¶

(7) Records and documentation:¶

(a) To be eligible for reimbursement, providers must comply with all dental services rules, criteria, billing, and limits in this Chapter 410 Division 123 and Chapter 410 Division 120 and shall maintain records that fully support the extent of the service(s) and all procedure codes for which payment is requested;¶

(b) Providers must maintain clinical, financial and other records, capable of being audited or reviewed, as required under Chapter 410 Division 120 and Chapter 410 Division 141; ¶

(c) Providers must keep records for seven (7) years. Providers contracted with a CCO must meet the record retention requirements in OAR 410-141-3520; and¶

(d) Providers must have in each client's medical record a detailed description of the clinical indications and dental necessity of the dental service(s), including, but not limited to, the tooth number(s), surface(s), pocket depth(s), and radiographs. The provider must annotate the clinical record each time a service is provided and sign and date the record prior to submitting a claim for payment.

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.065

AMEND: 410-124-0000

RULE SUMMARY: Remove references to a funding line on the Prioritized List. Update reference to the OHA Prioritized List. Replace references to a "client" with "Member." Capitalize defined terms.

CHANGES TO RULE:

410-124-0000

Transplant Services ¶

(1) The ~~Health Systems Division (Division)~~ Division shall make payment for transplant services identified in these rules as covered for eligible ~~Medicaid client members~~ defined in OAR 410-124-0010 that meet the transplant criteria outlined in OAR 410-124-0000 through 410-124-0040 and the OHA Prioritized List of Health Services guideline notes. ¶

(2) The Division shall reimburse for transplants if: ¶

(a) All Division criteria are met; and ¶

(b) ~~Transplants are medically necessary~~ and meet the requirements for ~~p~~Physician and ~~h~~Hospital services; and ¶

(c) The ICD-10-CM ~~d~~Diagnosis ~~e~~Code(s) and CPT transplant procedure code(s) are paired on the same ~~currently funded~~ line on the OHA Prioritized List of Health Services adopted under OAR 410-141-3830. ¶

(3) The following transplants are covered by the Division if the criteria in (2) above is met: ¶

(a) Solid organ, heart, kidney, liver, lung, heart-lung, pancreas, kidney-pancreas, and small bowel; ¶

(b) Bone marrow and peripheral stem cell; ¶

(c) Corneal transplants; ¶

(d) Simultaneous multiple organ transplants are covered only if specifically identified as paired on the same ~~currently funded line on the Oregon Health Plan (OHP)~~ line on the OHA Prioritized List of Health Services whether the transplants are for the same underlying disease or for unrelated, but concomitant, underlying diseases. ¶

(4) Not Covered Transplant Services: The following types of transplants are not covered by the Division: ¶

(a) Transplants which are considered experimental or investigational or which are performed on an experimental or investigational basis, as determined by the Division; ¶

(b) ~~Second bone marrow transplants are not covered except for tandem autologous transplants for multiple myeloma.~~ ¶

(c) Transplants which are not described as covered in OAR 410-141-3830.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

AMEND: 410-125-0045

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-125-0045

Coverage and Limitations ¶

In general, most medically necessary and appropriate services are covered. There are, however, some restrictions and limitations. Please refer to the ~~Division of Medical Assistance Programs' (Division) General Rules Program~~ Oregon Administrative Rules (OAR) in Chapter 410, Division 120 and the Oregon Health Authority's (Authority) other Medical Assistance OARs found in Chapter 410 for information on general scope of coverage and limitations. Some of the limitations and restrictions that apply to hospital services are: ¶

(1) Prior authorization (PA): Some services require PA for the Oregon Health Plan (OHP) Plus Benefit Package ~~check. In order to determine which services require PA for the OHP Plus Benefit Package, refer to~~ OAR 410-125-0080. ¶

(2) Non-covered services: ¶

(a) Services that are not medically necessary and appropriate, unproven medical efficacy or services that are the responsibility of another Department of Human Services (Department) or Oregon Health Authority (Authority) ~~Division~~ are not covered by the ~~Division of Authority's~~ Medical Assistance Programs; ¶

(b) Service coverage is based on the ~~Health Evidence Review Commission's (HERC)~~ OHA Prioritized List of Services and the client's benefit package; ¶

(c) See the ~~G~~general Rules for the Authority's Medical Assistance Programs (chapter 410, division 120) and other program divisions in chapter 410 for a list of services that are not covered services. Further information on covered and non-covered services is found in the Revenue Code section in the Hospital Services Supplemental Information; on the Oregon Health Authority's Health Systems Division's webpage. ¶

(3) Limitations on hospital benefit days: Clients have no hospital benefit day limitations for treatment of covered services. ¶

(4) Dental services: Clients have dental/denturist services identified as covered on the ~~HERC~~ OHA Prioritized List (OAR 410-141-5223-1260). ¶

(5) ~~S~~Hospital services provided outside of the hospital's licensed facilities; for example: ¶

(a) Services provided in the client's home or in a nursing home, are not covered by ~~Division~~ the Authority as hospital services. ~~The only exceptions to this are Maternity Case Management services and specific nursing or physician services;~~ ¶

(b) There are a limited number of hospital services that are covered when they are provided during a ground or air ambulance transport outside a hospital's licensed facility, which include the following: ¶

(~~6~~A) Dialysis services require a written physician prescription. The prescription must indicate the ICD-10 diagnosis code and must be retained by the provider of dialysis services for the period of time specified in the General Rules Program Caring Contacts services (described in OAR 333-520-0700); ¶

(B) Maternity Case Management services (described in OAR 410-130-0595); and ¶

(C) Specific nursing or physician services provided during a ground or air ambulance transport (described in OAR 410-136-3180).

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-125-0080

Inpatient Services ¶¶

(1) Elective (not urgent or emergent) hospital admission:¶¶

(a) Coordinated Care Organization (CCO) and Mental Health Organization (MHO) clients: Contact the client's CCO, or MHO. The health plan may have different prior authorization (PA) requirements than the Division;¶¶

(b) Medicare clients: The Division does not require PA for inpatient services provided to clients with Medicare Part A or B coverage;¶¶

(c) Division clients: Oregon Health Plan (OHP) clients covered by the OHP Plus Benefit Package:¶¶

(A) For a list of medical and surgical procedures that require PA, see the Division's Medical-Surgical Services Program, rules OAR chapter 410, division 130, specifically OAR 410-130-0200, table 130-0200-1, unless they are urgent or emergent defined in OAR 410-125-0401;¶¶

(B) For PA, contact the Division unless otherwise indicated in the Medical-Surgical Service program rules, specifically OAR 410-130-0200, Table 130-0200-1.¶¶

(2) Transplant services:¶¶

(a) Complete rules for transplant services are in the Division's Transplant Services Program rules, OAR chapter 410, division 124;¶¶

(b) Clients are eligible for transplants covered by the ~~Oregon Health Evidence Review Commission's~~ OHA Prioritized List of Health Services (OHA Prioritized List). See the Transplant Services Program administrative rules for criteria. ¶¶

(3) Out-of-State non-contiguous hospitals:¶¶

(a) All non-emergent and non-urgent services provided by hospitals more than 75 miles from the Oregon border require PA;¶¶

(b) Contact the Division's Medical Director's office for authorization for clients not enrolled in a Prepaid Health Plan (PHP). For clients enrolled in a PHP, contact the plan.¶¶

(4) Out-of-State contiguous hospitals: The Division prior authorizes services provided by contiguous-area hospitals, less than 75 miles from the Oregon border, following the same rules and procedures governing in-state providers.¶¶

(5) Transfers to another hospital:¶¶

(a) Transfers for the purpose of providing a service listed in the Medical-Surgical Services program rules, specifically OAR 410-130-0200, Table 130-0200-1, e.g., inpatient physical rehabilitation care, require PA. (b) For transfers to a skilled nursing facility, intermediate care facility, or swing bed, contact Aging and People with Disabilities (APD). APD reimburses nursing facilities and swing beds through contracts with the facilities. For CCO clients, transfers require authorization and payment (for first 20 days) from the CCO;¶¶

~~(e)~~ (b) For transfers for the same or lesser level inpatient care to a general acute-care hospital, the Division shall cover transfers, including back transfers that are primarily for the purpose of locating the patient closer to home and family, when the transfer is expected to result in significant social or psychological benefit to the patient:¶¶

(A) The assessment of significant benefit shall be based on the amount of continued care the patient is expected to need (at least seven days) and the extent to which the transfer locates the patient closer to familial support;¶¶

(B) Payment for transfers not meeting these guidelines may be denied on the basis of post-payment review.¶¶

~~(d)~~ (c) Exceptions:¶¶

(A) Emergency transfers do not require PA;¶¶

(B) In-state or contiguous non-emergency transfers for the purpose of providing care that is unavailable in the transferring hospital do not require PA unless the planned service is listed in the Medical-Surgical Service Program rules, specifically OAR 410-130-0200, Table 130-0200-1;¶¶

(C) All non-urgent transfers to out-of-state, non-contiguous hospitals require PA.¶¶

(6) Dental procedures provided in a hospital setting:¶¶

(a) For prior authorization requirements, see the Division's Dental Services Program rules; specifically OAR 410-123-1260 and 410-123-1490;¶¶

(b) Emergency dental services do not require PA;¶¶

(c) For prior authorization for fee-for-service clients, contact the Division's Dental Services Program analyst. (See the Division's Dental Services Program Supplemental information, <http://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Dental.aspx>);¶¶

- (d) For clients enrolled in a CCO, contact the client's health plan.¶¶
 - (7) Long-term acute care (LTAC) hospital services authorization requirements:¶¶
 - (a) For an initial thirty-day stay:¶¶
 - (A) LTAC provider must, before admitting the client, submit a request for prior authorization to the Division;¶¶
 - (B) Include sufficient medical information to justify the requested initial stay;¶¶
 - (C) Meet the clinical criteria outlined in the LTAC Hospital guide at:
<http://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Hospital.aspx>.¶¶
 - (b) Extension of stay:¶¶
 - (A) Submit request for prior authorization to the Division;¶¶
 - (B) Include sufficient medical justification for the extended stay.
- Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Remove reference to a funding line on the Prioritized List. Update reference to the OHA Prioritized List. Replace references to a "client" with "Member." Capitalize defined terms.

CHANGES TO RULE:

410-127-0040

Coverage ¶

- (1) Medically ~~a~~Appropriate ~~h~~Home ~~h~~Health ~~s~~Services may be covered on a visiting basis to eligible ~~client~~Members as ordered by a ~~p~~Physician and part of a written ~~p~~Plan of ~~e~~Care. Coverage of ~~h~~Home ~~h~~Health ~~s~~Services is not contingent on the ~~client~~Member needing ~~n~~Nursing, ~~n~~Nursing ~~f~~Facility or therapy services. ¶
- (2) Home ~~h~~Health ~~s~~Services may be provided in the ~~client~~Member's ~~h~~Home or any setting in which normal life activities take place other than a ~~h~~Hospital, ~~n~~Nursing ~~f~~Facility, intermediate care facility for individuals with intellectual disabilities, any setting that exists primarily for the purpose of providing medical/nursing care, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. ¶
- (3) Home ~~h~~Health ~~s~~Services require a face-to-face encounter as described in OAR 410-127-0045 consistent with federal Medicaid regulations at 42 CFR 440.70. ¶
- (4) Home ~~h~~Health ~~s~~Services must be prescribed by a ~~p~~Physician, and the signed order must be on file at the ~~h~~Home ~~h~~Health ~~a~~Agency. The prescription must include the ICD-10-CM diagnosis code indicating the reason the ~~h~~Home ~~h~~Health ~~s~~Services are requested. The orders on the ~~p~~Plan of ~~e~~Care must specify the type of services to be provided to the ~~client~~Member with respect to the professional who will provide them, the nature of the individual services, specific frequency, and specific duration. The orders must clearly indicate how many times per day, each week or each month the services are to be provided. The ~~p~~Plan of ~~e~~Care must include the ~~client~~Member's condition, the rationale for the care plan including justification for the required skill level of care, and the summary of care for additional certification periods. ¶
- (5) The ~~p~~Plan of ~~e~~Care must be reviewed and signed by the ~~p~~Physician who established the ~~p~~Plan of ~~e~~Care at least every 60 days to continue services. ¶
- (6) The following services or items are covered, if diagnoses are on the ~~portion of the pOHA Prioritized L~~ist ~~above the line funded by the legislature~~. ¶
- (a) Skilled ~~n~~Nursing ~~s~~Services; ¶
- (b) Skilled nursing evaluation (includes Outcome and Assessment Information Set (OASIS) assessment); ¶
- (c) Home ~~h~~Health ~~a~~Aide ~~s~~Services; ¶
- (d) Occupational ~~t~~Therapy services; ¶
- (e) Occupational ~~t~~Therapy evaluation, which may include OASIS assessment; ¶
- (f) Physical ~~t~~Therapy services; ¶
- (g) Physical ~~t~~Therapy evaluation, which may include OASIS assessment; ¶
- (h) Speech-~~L~~anguage ~~p~~Pathology ~~s~~Services, which may include OASIS assessment; ¶
- (i) Speech-language pathology evaluation, which may include OASIS assessment; ¶
- (j) Medical and surgical supplies.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Remove reference to a funding line on the Prioritized List. Update reference to the OHA Prioritized List. Update OAR reference to 410-141-3830. Replace references to a "client" with "Member." Capitalize defined terms.

CHANGES TO RULE:

410-127-0060

Reimbursement and Limitations ¶

- (1) The Division reimburses ~~h~~Home ~~h~~Health ~~s~~Services on a fee schedule by type of visit (see home health rates on the Authority's website at: <http://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Home-Health.aspx>). ¶
- (2) The Division recalculates its ~~h~~Home ~~h~~Health ~~s~~Services rates every other year. The Division shall reimburse ~~h~~Home ~~h~~Health ~~s~~Services at a level of 74 percent of Medicare costs reported on the audited, most recently accepted or submitted Medicare Cost Reports prior to the rebase date and pending approval from the Centers for Medicare and Medicaid Services (CMS), and, if indicated, legislative funding authority. ¶
- (3) The Division shall request the Medicare Cost Reports from ~~h~~Home ~~h~~Health ~~a~~Agencies with a due date and shall recalculate potential rates based on the Medicare Cost Reports received by the requested due date. The ~~h~~Home ~~h~~Health ~~a~~Agency shall submit requested cost reports by the date requested. ¶
- (4) The Division reimburses only for services that are ~~m~~Medically ~~a~~Appropriate. ¶
- (5) Limitations: ¶
- (a) Limits of ~~e~~Covered ~~s~~Services: ¶
- (A) Skilled nursing visits are limited to two (2) visits per day with payment authorization; ¶
- (B) All therapy services are limited to one (1) visit or evaluation per day for ~~p~~Physical ~~t~~Therapy, ~~e~~Occupational ~~t~~Therapy, or ~~s~~Speech-~~l~~Language ~~p~~Pathology ~~s~~Services. Therapy visits require payment authorization; ¶
- (C) Home health aide services are limited to those ordered by a ~~p~~Physician, included in the plan of care, permitted to be performed under state law, consistent with home health aide training, and under the direction of a registered nurse or licensed therapist familiar with the ~~client~~Member and the ~~client~~Member's plan of care. These services must not duplicate other Medicaid-paid personal care services. ¶
- (D) The Division shall authorize home health visits for ~~client~~Members with uterine monitoring only for medical problems that could adversely affect the pregnancy and are not related to the uterine monitoring; ¶
- (E) Medical supplies must be billed at ~~a~~Acquisition ~~e~~Cost, and the total of all medical supply revenue codes may not exceed \$50 per day. Only supplies that are used during the visit or the specified additional supplies used for current ~~client~~Member/caregiver teaching or training purposes as ~~m~~Medically ~~a~~Appropriate are billable. ~~Client~~Member visit notes must include documentation of supplies used during the visit or supplies provided according to the current plan of care; ¶
- (F) Durable medical equipment must be obtained by the ~~client~~Member by prescription through a durable medical equipment ~~p~~Provider. ¶
- (b) Services not covered: ~~when~~: ¶
- (A) ~~S~~A service not ~~m~~Medically ~~a~~Appropriate; ¶
- (B) A service for a diagnosis that does not appear on ~~a line of the the OHA~~ Prioritized List of Health Services ~~that has been funded by the Oregon Legislature (OAR 410-141-0523830)~~; ¶
- (C) Medical social worker service; ¶
- (D) Registered dietician counseling or instruction; ¶
- (E) Drug and biological; ¶
- (F) Fetal non-stress testing; ¶
- (G) Respiratory therapist service; ¶
- (H) Flu shot; ¶
- (I) Psychiatric nursing service.
- Statutory/Other Authority: ORS 413.042
- Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-129-0020

Therapy Plan of Care, Goals, Outcomes, and Record Requirements ¶¶

(1) Therapy shall be based on a prescribing practitioner's written order and therapy treatment plan with goals and objectives developed from an evaluation or re-evaluation. The limits, authorization, and plan of treatment criteria apply to both rehabilitative and habilitative therapy. The definition for both is the following:¶¶

(a) "Rehabilitative Services" means health care services that help an individual re-establish, restore, or improve skills and functioning for daily living that have been lost or impaired due to illness, injury, or disability;¶¶

(b) "Habilitative Services" means health care services that help an individual keep, learn, or improve skills and functioning for daily living, designed to establish skills that have not yet been acquired at an age-appropriate level. Examples include therapy for a child who is not walking or talking at the expected age.¶¶

(2) A total of thirty (30) visits per year of rehabilitative therapy and a total of thirty (30) visits per year of habilitative therapy (speech therapy) are included when medically appropriate. Additional visits, not to exceed thirty (30) visits per year of rehabilitative therapy and thirty (30) visits per year of habilitative therapy, may be authorized in cases of a new acute injury, surgery, or other significant change in functional status. Children under age 21 may have additional visits authorized beyond these limits if medically necessary and medically appropriate, pursuant to 42 CFR § 441 Subpart B.¶¶

(3) The therapist shall teach the therapy regimen to individuals, including the client, family members, foster parents, and caregivers who can assist in the achievement of the goals and objectives. The client must be present when the therapy is appropriately demonstrated at the time of teaching to assure that the therapy regimen is performed safely and correctly. The Division may not authorize extra treatments for teaching.¶¶

(4) All Speech-Language Pathology (SLP) treatment services require a therapy plan of care that is required for claims subject to prepayment review (PPR) or requiring Prior Authorization (PA) for payment.¶¶

(5) The Division shall provide authorization for the level of care or type of service that meets the client's medical need consistent with the ~~Health Evidence Review Commission's (HERC)~~OHA Prioritized List of Health Services (OHA Prioritized List) and the American Hippotherapy Association's (AHA) position on coding and billing for equine related modalities.¶¶

(6) These rules do not limit or affect any obligations of a school district or education entity eligible for reimbursement for covered, health-related services provided in support of a child with a disability education program required by state and federal law. School-sponsored services are supplemental to other health plan therapy services and are not considered duplicative. See OAR chapter 410, division 133 SBHS rules for services provided by public education providers and OAR 410-141-3565 (Managed Care Entity (MCE) Billing).¶¶

(7) The SLP therapy plan must adhere to the licensing board requirements of care and shall include:¶¶

(a) Client's name and ICD diagnosis code;¶¶

(b) The type, amount, frequency, and duration of the proposed rehabilitative or habilitative therapy;¶¶

(c) Individualized, measurably objective, short-term and long-term functional goals;¶¶

(d) Dated signature of the therapist or the prescribing practitioner establishing the therapy plan of care; and¶¶

(e) Evidence of certification of the therapy plan of care by the prescribing practitioner.¶¶

(8) SLP therapy records must be compliant with applicable record and documentation requirements (see Oregon Administrative Rules in chapter 335, division 010).¶¶

(9) Documentation of clinical activities may be supplemented using flowsheets or checklists; however, these may not substitute for or replace detailed documentation of assessments and interventions.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, ORS 414.065

RULE SUMMARY: Remove reference to a funding line on the Prioritized List. Update reference to the OHA Prioritized List. Update OAR reference to OARs 410-141-3825 and 410-141-3830.

CHANGES TO RULE:

410-129-0200

Speech-Language Pathology Procedure Codes ¶

(1) Inclusion of a current procedural terminology (CPT) or healthcare common procedure coding system (HCPCS) code in sections (2), (3) and (4) does not mean a code is covered. Refer to OAR 410-141-0480, 410-141-0500, and 410-141-0520 for information on coverage. ¶

(2) The following Speech therapy services are subject to PPR when paired ~~above the funding line on the HERC~~ ~~POHA Prioritized List~~ (see OAR 410-141-~~0523830~~), when visits have not exceeded the allowed 30 habilitative and 30 rehabilitative visits allowed in a calendar year. ¶

(a) 92507 Treatment of speech, language, voice, communication and auditory processing disorder, individual; and ¶

(b) 92508 Group, two or more individuals. ¶

(3) PA is required for SLP services. ¶

(a) When there is documented need for extended service, considering 60 minutes as the maximum length of a treatment session; ¶

(b) When there is documented need for continuing rehabilitative or habilitative therapy, considering 30 habilitative and 30 rehabilitative visits in a calendar year; ¶

(c) When requesting services for treatments that ~~are below the funded line~~ do not appear on the OHA Prioritized List or not are otherwise excluded from coverage per OAR 410-141-~~0480;3825~~; ¶

(d) For the following services: ¶

(A) E2500 Speech generating device, digitized speech, using prerecorded messages, less than or equal to eight minutes recording time; ¶

(B) E2502 Speech generating device, digitized speech, using prerecorded messages, greater than eight minutes but less than 20 minutes; ¶

(C) E2504 Speech generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than 40 minutes; ¶

(D) E2506 Speech generating device, digitized speech, using prerecorded messages, greater than 40 minutes recording time; ¶

(E) E2508 Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device; ¶

(F) E2510 Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access; ¶

(G) E2511 Speech generating software program for personal computer or personal digital assistance; ¶

(H) E2512 Accessory for speech generating device, mounting system; ¶

(I) E2599 Accessory for speech generating device, not otherwise classified; ¶

(J) L7520 Repair prosthetic device, labor component, for 15 minutes; ¶

(K) L8510 Voice amplifier; and ¶

(L) V5336 Repair, modification of augmentative communication system or device excluding adaptive hearing aid. ¶

(4) Services not subject to PPR or PA: ¶

(a) 92521 Evaluation of speech fluency (e.g., stuttering, cluttering); ¶

(b) 92522 Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); ¶

(c) 92523 Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (e.g., receptive and expressive language); ¶

(d) 92524 Behavioral and qualitative analysis of voice and resonance; ¶

(e) 92597 Evaluation for use and fitting of voice prosthetic device to supplement oral speech; ¶

(f) 92607 Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient, first hour; ¶

(g) 92610 Evaluation of oral and pharyngeal swallowing function, limited to two per 12-month period; ¶

(h) 92608 Each additional 30 minutes (List separately in addition to code for primary procedure); ¶

(i) 92611 Motion fluoroscopic evaluation of swallowing function by cine or video recording, limited to two per 12-month period; ¶

(j) S9152 Speech therapy, re-evaluation, limited to four per 12-month period; ¶

(k) A4649 Supplies for speech therapy, limited to two per calendar year not to exceed \$4.75 each; ¶

- (l) 92526 Treatment of swallowing dysfunction and oral function for feeding;_¶
 - (m) 92609 Therapeutic services for the use of speech-generating device, including programming and modification;_¶
 - (n) L7510 Repair of prosthetic device, repair or replace minor parts;_¶
 - (o) L8500 Artificial larynx, any type;_¶
 - (p) L8501 Tracheostomy speaking valve;_¶
 - (q) L8507 Tracheoesophageal voice prosthesis, patient inserted, any type, each;_¶
 - (r) L8509 Tracheoesophageal voice prosthesis, inserted by a licensed health provider, any type;_¶
 - (s) L8515 Gelatin capsule, application device for use with tracheoesophageal voice prosthesis, each; and_¶
 - (t) L9900 Orthotic and prosthetic supply necessary or service component of another HCPCS L code (PA required).
- Statutory/Other Authority: ORS 413.042
- Statutes/Other Implemented: ORS 414.025, ORS 414.065

AMEND: 410-130-0000

RULE SUMMARY: Update URL reference for the Prioritized List. Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-130-0000

Foreword ¶¶

(1) The Division Medical-Surgical Services rules are designed to assist medical-surgical providers to deliver medical services and prepare health claims for clients with Medical Assistance Program coverage. Providers must follow the Division rules in effect on the date of service.¶¶

(2) The Division enrolls only the following types of providers as performing providers under the Medical-Surgical program:¶¶

(a) Doctors of medicine, osteopathy and naturopathy;¶¶

(b) Podiatrists;¶¶

(c) Acupuncturists;¶¶

(d) Licensed Physician associates;¶¶

(e) Nurse practitioners;¶¶

(f) Laboratories;¶¶

(g) Family planning clinics;¶¶

(h) Social workers (for specified services only);¶¶

(i) Licensed Direct entry midwives;¶¶

(j) Portable x-ray providers;¶¶

(k) Ambulatory surgical centers;¶¶

(l) Chiropractors;¶¶

(m) Licensed Dietitians (for specified service only);¶¶

(n) Registered Nurse First Assistants;¶¶

(o) Certified Nurse Anesthetists;¶¶

(p) Clinical Pharmacists;¶¶

(q) Birthing Centers;¶¶

(r) Licensed Genetic Counselor.-¶¶

(3) For clients enrolled in a managed care plan, contact the client's plan for coverage and billing information.¶¶

(4) The Medical-Surgical Services rules contain information on policy, special programs, prior authorization, and criteria for some procedures. All Division rules are intended to be used in conjunction with the General Rules for Oregon Medical Assistance Programs (OAR 410 division 120) and the Oregon Health Plan (OHP) Administrative Rules (OAR 410 division 141).¶¶

(5) The ~~Health Services Commission's~~ OHA Prioritized List of Health Services is found on their website at:

~~www.oregon.gov/OHA/HPA/CSI-Herc/Pages/Prioritized-List.aspx~~ web TBD].

Statutory/Other Authority: ORS 413.042, 676.730

Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-130-0160

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-130-0160

Codes ¶

(1) ICD-10-CM Diagnosis Codes:¶

(a) Always use the principal diagnosis code in the first position to the highest degree of specificity. List additional diagnosis codes if the claim includes charges for services that relate to the additional diagnoses. However, it is not necessary to include more than one diagnosis code per procedure code;¶

(b) Diagnosis codes are required on all billings including those from independent laboratories and portable radiology including nuclear medicine and diagnostic ultrasound providers;¶

(c) Always supply the ICD-10-CM diagnosis code to ancillary service providers when prescribing services, equipment, and supplies.¶

(2) CPT and HCPCS Codes:¶

(a) Use only codes from the current year for Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes;¶

(b) Effective January 1, 2005, HIPAA regulations prohibit the use of a grace period for codes deleted from CPT or HCPCS. In the past the grace period was from January 1 through March 31;¶

(c) The division may consider reimbursement for CPT category III codes included under the following headings: Adaptive Behavior Assessments, Adaptive Behavior Treatment, and Exposure Adaptive Behavior Treatment With Protocol Modification. All CPT category II (codes with fifth character of "F") and all other category III codes (codes with fifth character "T") are not Division of Medical Assistance Programs' (Division) covered services;¶

(d) Use the most applicable CPT or HCPCS code. Do not fragment coding when services can be included in a single code (see the "Bundled Services" section of this rule). Do not use both CPT and HCPCS codes for the same procedure. This is considered duplicate billing.¶

(3) The Medical-Surgical Service rules list the HCPCS/CPT codes that require authorization or have limitations. The ~~Health Evidence Review Commission's~~ OHA Prioritized List of Health Services (OAR 410-141-3830) determines covered services.¶

(4) For determining the appropriate level of service code for Evaluation and Management services, read the definitions in the CPT and HCPCS codebook. Use the definitions to verify level of service, especially for office visits. Unless otherwise specified in the Medical-Surgical provider rule, use the guidelines from CPT and HCPCS.¶

(5) Bundled Services: Reimbursements for some services are "bundled" into the payment for another service. The Division does not make separate payment for bundled services and clients may not be billed for bundled services. The Division's Not Covered/Bundled Services rule, OAR 410-130-0220, provides more information regarding bundled services.¶

[Publications: Publications referenced are available from the agency.]

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-130-0190

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-130-0190

Tobacco Cessation ¶

(1) Tobacco treatment interventions may include one or more of these services: basic, intensive, and telephone calls.¶

(2) Basic tobacco cessation treatment includes the following services:¶

(a) Ask - systematically identify all tobacco users - usually done at each visit;¶

(b) Advise - strongly urge all tobacco users to quit using;¶

(c) Assess - the tobacco user's willingness to attempt to quit using tobacco within 30 days;¶

(d) Assist - with brief behavioral counseling, treatment materials and the recommendation/prescription of tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum);¶

(e) Arrange - follow-up support and/or referral to more intensive treatments, if needed.¶

(3) When providing basic treatment, include a brief discussion to address client concerns and provide the support, encouragement, and counseling needed to assist with tobacco cessation efforts. These brief interventions, less than 6 minutes, generally are provided during a visit for other conditions, and additional billing is not appropriate.¶

(4) Intensive tobacco cessation treatment is on the ~~Health Services Commission's~~ OHA Prioritized List of Health Services and is covered if a documented quit date has been established. This treatment is limited to ten sessions every three months. Treatment is reserved for those clients who are not able to quit using tobacco with the basic intervention measures.¶

(5) Intensive tobacco cessation treatment includes the following services:¶

(a) Multiple treatment encounters (up to ten in a 3 month period);¶

(b) Behavioral and tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum);¶

(c) Individual or group counseling, six minutes or greater.¶

(6) Telephone calls: the Division may reimburse a telephone call intended as a replacement for face-to-face contact with clients who are in intensive treatment as it is considered a reasonable adjunct to, or replacement for, scheduled counseling sessions:¶

(a) The call must last six to ten minutes and provides support and follow-up counseling;¶

(b) The call must be conducted by the provider or other trained staff under the direction or supervision of the provider;¶

(c) Enter proper documentation of the service in the client's chart.¶

(7) Diagnosis Code ICD-10-CM (F17.200-F17.299; Nicotine Dependence):¶

(a) Use as the principal diagnosis code when the client is enrolled in a tobacco cessation program or if the primary purpose of the visit is for tobacco cessation services;¶

(b) Use as a secondary diagnosis code when the primary purpose of this visit is not for tobacco cessation or when the tobacco use is confirmed during the visit.¶

(8) Billing Information: Coordinated care organizations and managed care plans may have tobacco cessation services and programs. This rule does not limit or prescribe services a Prepaid Health Plan provides to clients receiving OHP benefits.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-130-0200

RULE SUMMARY: Update reference to the OHA Prioritized List. Remove reference to the COVID-19 public health emergency.

CHANGES TO RULE:

410-130-0200

Prior Authorization ¶¶

(1) For fee-for-service (FFS) clients, Prior Authorization (PA) is required for all procedure codes listed in Table 130-0200-1. PA is required in all settings unless otherwise indicated. See indicators in table heading. For details on where to obtain PA, download a copy of the Prior Authorization Handbook at:

<http://www.oregon.gov/oha/HSD/OHP/Tools/Prior%20Authorization%20Handbook.pdf>.¶¶

(2) Providers must obtain PA from the OHP payer, either FFS or CCO; that shall be responsible for payment at the time the service is delivered.¶¶

(3) The Division shall authorize for the level of care or type of service that meets the client's medical need consistent with the ~~Health Evidence Review Commission's (HERC)~~OHA Prioritized List of Health Services (OHA Prioritized List) and guideline notes, as referenced in OAR 410-141-3830.¶¶

(4) Codes for which medical need has not been specified by the ~~HERC~~OHA shall be authorized based on medical appropriateness as the term is defined in OAR 410-120-0000.¶¶

(5) PA requests for coverage of planned births taking place in a clinic, birth center or home setting will be referred to as community births or as out-of-hospital births. To obtain PA for coverage of these services, providers must meet the requirements and submit the forms and required supporting documentation as described in the Planned Community Births (Out-of-Hospital Births) Prior Authorization and Billing Guide, effective September 2021 available at: <https://www.oregon.gov/oha/HSD/OHP/Tools/Planned-Community-Birth-Guide.pdf>.¶¶

~~(a) Due to the current COVID-19 public health emergency and surge in Oregon cases impacting hospital capacities, initial documentation to assess pregnancy risk per OAR 410-130-0240 must be received by the Division no later than 38 weeks, 0 days gestation, through the COVID health emergency or until rescinded or revised by the Division;¶¶~~

(b) Documentation requirements reflecting prior prenatal care must be met. Requests for ongoing documentation to continue the support of assessment of pregnancy risk must also be met per OAR 410-120-1320(2)(3).¶¶

(6) PA is not required:¶¶

(a) For clients with both Medicare and Medical Assistance Program coverage, and the service is covered by Medicare. However, PA is still required for bariatric surgeries and most transplants, even if they are covered by Medicare;¶¶

(b) For kidney and cornea transplants unless they are performed out-of-state;¶¶

(c) For emergent procedures or services;¶¶

(d) For hospital admissions unless the procedure requires PA.¶¶

(7) A second opinion may be requested by the Division or the contractor before PA is given.¶¶

(8) Treating and performing practitioners are responsible for obtaining PA.¶¶

(9) PA documentation must be complete and legible.¶¶

(10) PA shall be considered based on the documentation submitted.¶¶

(11) Refer to Table 130-0200-1 for all services and procedures requiring PA.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-130-0200.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:

<https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=340232>

AMEND: 410-130-0220

RULE SUMMARY: Remove reference to a funding line on the Prioritized List. Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-130-0220

Not Covered/Bundled Services/Not Valid ¶¶

(1) Under the Division's Fee-for-Service Medical-Surgical program, no payment shall be made for (a) and (b) of this section except in accordance with applicable exceptions as defined in administrative rule:¶¶

(a) For the purposes of this rule, the billing codes that are not covered shall be:¶¶

(A) Services ~~below the funding line not included on~~ or otherwise specified as not covered on the ~~Health Evidence Review Commission (HERC)~~OHA Prioritized List of Health Services as referenced in OAR 410-141-3830;¶¶

(B) Services specified in OAR 410-120-1200;¶¶

(C) For Ambulatory Surgical Centers, services listed on Medicare's ASC Covered Surgical Procedures file addendum EE, Surgical Procedures to Be Excluded from Payment in ASCs as referenced in OAR 410-120-1340.¶¶

(b) For the purposes of this rule, the billing codes that are not eligible for separate reimbursement shall be:¶¶

(A) Services listed in Medicare's Physician Fee Schedule RVU file as referenced in OAR 410-120-1340 that have a code status of B (Bundled Code) or P (Bundled/Excluded Codes). Services billed with billing codes 98960-98962 are excepted from this subsection and may be reimbursed separately;¶¶

(B) For Ambulatory Surgical Centers, services listed on Medicare's ASC Covered Surgical Procedures file as referenced in OAR 410-120-1340 that have payment indicator N1 (Packaged service) or L1 (Packaged item/service);¶¶

(C) Certain services listed in the Medicare's Physician Fee Schedule RVU file that have a code status of I (Not valid for Medicare purposes) as referenced in OAR 410-120-1340. Services with this status code are eligible for separate reimbursement only when listed on the Authority's published fee schedule;¶¶

(D) Services listed in the Medicare's Physician Fee Schedule RVU file that have a code status of M (Measurement codes) or Q (Therapy functional information code) as referenced in OAR 410-120-1340.¶¶

(2) In the event that a covered Fee-for-Service Medical-Surgical program service does not have a payment methodology specified in OAR 410-120-1340 or in other program specific rules, the division may set a reasonable rate for the service's billing codes or designate that the service's billing codes do not pay separately. No reimbursement shall be made for services designated to not pay separately.¶¶

(3) Nothing in this rule is intended to prevent payment for services by CCOs or in programs other than the Division's Fee-for-Service Medical-Surgical program. See applicable rules for CCO payment and other programs. Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-130-0240

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-130-0240

Medical Services ¶

(1) Coverage of medical and surgical services is subject to the ~~Health Evidence Review Commission's (HERC)~~OHA Prioritized List of Health Services (OHA Prioritized List). Medical and surgical services requiring prior authorization (PA) are listed in Oregon administrative rule (OAR or rule) 410-130-0200, PA Table 130-0200-1, and medical and surgical services that are Not Covered/Bundled services are listed in OAR 410-130-0220, Table 130-0220-1.¶

(2) Coverage for acupuncture services by an enrolled acupuncture provider are subject to the ~~HERC~~OHA Prioritized List and the client's benefit plan.¶

(3) Coverage for medically appropriate chiropractic services provided by an enrolled chiropractor is subject to the ~~HERC~~OHA Prioritized List and benefit plan for:¶

(a) Diagnostic visits including evaluation and management services;¶

(b) Chiropractic care including manipulative treatment;¶

(c) Laboratory and radiology services.¶

(4) Maternity care and delivery:¶

(a) The Division may consider payment for delivery within a hospital, clinic, birthing center, or home setting;¶

(b) For out-of-hospital births, the Division may only consider payment for labor and delivery care of women experiencing low risk pregnancy. The Division will determine whether a pregnancy can be considered low risk and an out-of-hospital birth is eligible for payment;¶

(c) During the Coronavirus (COVID-19) outbreak state of emergency initiated under governor Kate Brown's executive order 20-03 and any subsequent executive order extending the state of emergency, the division adopts tables 410-130-0240-1, 410-130-0240-2, 410-130-0240-3 and 410-130-0240-4, superseding the requirements in the OHA Prioritized List of Health Services Guideline Note 153 for the purposes described below.¶

(d) During the Coronavirus (COVID-19) outbreak state of emergency initiated under governor Kate Brown's executive order 20-03 and any subsequent executive order extending the state of emergency, the division adopts Table 410-130-0240-1 and Table 410-130-0240-3 to outline the absolute risk factors that, if present, would preclude payment for initiation or continuation of any out-of-hospital labor and delivery care. For a planned out-of-hospital birth, the Division requires that a contingency for an in-hospital birth be included in the medical record. The division considers all conditions listed in Tables 410-130-0240-1 and 410-130-0240-3 to necessitate an in-hospital birth if present or anticipated to be present at the onset of labor. The Division may deny payment for labor and delivery services in an out-of-hospital setting if it determines that an in-hospital birth was necessary and appropriate steps to facilitate an in-hospital birth were not pursued. The Division may also deny payment for services if appropriate risk assessments were not performed at initiation of care and throughout pregnancy, or when the appropriate consultation policies described in subsection (e) were not followed. When an in-hospital birth becomes necessary for a client that was seeking a planned out-of-hospital birth and care is transferred from one provider to another, the Division will consider payment for both providers for the portion of care provided. Bill using appropriate CPT and HCPCS codes.¶

(e) During the Coronavirus (COVID-19) outbreak state of emergency initiated under governor Kate Brown's executive order 20-03 and any subsequent executive order extending the state of emergency, the division adopts Table 410-130-0240-2 and Table 410-130-0240-4, which contain criteria requiring consultation regarding the management of risk factors during pregnancy and birth for patients receiving out-of-hospital birth care. The division may deny payment if any of the high-risk conditions in tables 410-130-0240-2 or 410-130-0240-4 arise during pregnancy, labor, delivery or the immediate postpartum period and no consultation with an appropriate provider occurs, or if the recommendations of the consulting provider are not adhered to by the out-of-hospital birth attendant in the out-of-hospital setting. For the purposes of consultation under this subsection, an appropriate consulting provider is one of the following:¶

(A) A provider (MD/DO or CNM) who has active admitting privileges to manage pregnancy in a hospital, or;¶

(B) An appropriate specialty consultant (e.g., maternal-fetal medicine, hepatologist, hematologist, psychiatrist).¶

(f) When a provider is practicing within the authorization of his or her license, the division may consider payment for administration of drugs and devices that are used in pregnancy, birth, postpartum care, newborn care, or resuscitation and that are deemed integral to providing safe care.¶

(g) For out-of-hospital births, drugs authorized in subsection (f) or this section are limited:¶

- (A) For out-of-hospital births, the Division will make no payment for general, spinal, caudal, or epidural anesthesia administered for care associated with labor and delivery;¶¶
- (B) For out-of-hospital births, the Division will make no payment for inducing, stimulating, or using chemical agents to augment labor during the first or second stages of labor;¶¶
- (C) For out-of-hospital births, the Division will consider payment for chemical agents administered to inhibit labor only as a temporary measure until referral or transfer of the client to a higher level of care is complete.¶¶
- (h) Within the home setting, the Division may consider payment for appropriate supplies in addition to delivery payment. The additional payment for supplies includes all supplies, equipment, staff assistance, and newborn screening cards;¶¶
- (i) During labor in an out-of-hospital setting, should any of the risk factors outlined in Table 410-130-0240-3 develop, the Division requires that the client will be transferred to a hospital, and the Division may deny payment for labor and delivery services if it determines that appropriate steps to facilitate the transfer were not pursued. Appropriate transfer of care must be in accordance with the practitioner's licensure requirements. When labor management does not result in a delivery, and the client is appropriately transferred to a higher level of care, the provider shall code for labor management only. Bill code 59899 and attach appropriate clinical documentation of services performed with respect to labor management. The Division may also deny payment for services if appropriate risk assessments were not performed during labor, or when the appropriate consultation policies described in subsection (e) were not followed;¶¶
- (j) For births in an out-of-hospital setting, should any of the risk factors outlined in Table 410-130-0240-3 develop during the postpartum period in the mother, the Division requires that the mother will be transferred to a hospital, and the Division may deny payment for labor and delivery services if it determines that appropriate steps to facilitate the transfer were not pursued. Appropriate transfer of care must be in accordance with the practitioner's licensure requirements. The Division will consider payment for both providers for the portion of care provided when appropriate. The Division may also deny payment for services if appropriate risk assessments were not performed at initiation of care and throughout pregnancy, or when the appropriate consultation policies described in subsection (e) were not followed;¶¶
- (k) For multiple vaginal births, use the appropriate CPT code for the first delivery. Use the delivery-only code for the subsequent deliveries. The Division will reimburse the first delivery at 100 percent and the subsequent deliveries at 50 percent of the delivery-only code's maximum allowance. For multiple babies delivered via cesarean section, the Division pays for the cesarean section only once.¶¶
- (l) The division may deny payment or authorization for planned out-of-hospital birth when conditions arise which in the Division's judgment create a situation in which a planned out-of-hospital birth is not medically appropriate. For example, having multiple risk conditions requiring consultation may increase the risk sufficiently to indicate the need for transfer of care.¶¶
- (5) Neonatal Intensive Care Unit (NICU) procedures:¶¶
- (a) Are reimbursed only to neonatologists and pediatric intensivists for services provided to infants when admitted to a Neonatal or Pediatric Intensive Care Unit (NICU/PICU). All other pediatricians must use other CPT codes when billing for services provided to neonates and infants;¶¶
- (b) Neonatal intensive care codes are not payable for infants on Extracorporeal Membrane Oxygenation (ECMO). Use appropriate CPT ECMO codes.¶¶
- (6) Neurology or Neuromuscular payment for polysomnograms and multiple sleep latency tests (MSLT) are each limited to two in a 12-month period.¶¶
- (7) Oral health services provided by medical practitioners may include an oral assessment and application of topical fluoride varnish during a medical visit for children. Refer to OAR 410-123-1260 Dental Services program rule.
- Statutory/Other Authority: ORS 413.042
- Statutes/Other Implemented: ORS 414.025, 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-130-0240.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:

<https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=340236>

AMEND: 410-130-0255

RULE SUMMARY: Update URL reference for the Prioritized List. Update OAR reference to 410-141-3820. Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-130-0255

Immunizations, Vaccines for Children, and Immune Globulins ¶¶

(1) The Division covers immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Oregon Immunization Program. The approved ACIP recommendations are found in Guideline Note 106 of the ~~Health Evidence Review Commission's~~ OHA Prioritized List of Health Services as referenced in OAR 410-141-053820, ~~<http://www.oregon.gov/OHA/HPA/CIS-HERC/Pages/Prioritized-List.aspx>~~ [web TBD]. ¶¶

(2) Providers shall follow the (ACIP) guidelines for immunization schedules. Exceptions include: ¶¶

(a) On a case-by-case basis, provider may use clinical judgment in accordance with accepted medical practice to provide immunizations on a modified schedule, and; ¶¶

(b) On a case-by-case basis, provider may modify immunization schedule in compliance with the laws of the State of Oregon, including laws relating to medical and non-medical exemptions for immunizations. ¶¶

(3) Providers are encouraged to administer combination vaccines when medically appropriate and cost effective. ¶¶

(4) Providers must use standard billing procedures for adults and for any vaccines that are not part of the Vaccines for Children (VFC) Program. ¶¶

(5) Vaccines for Children (VFC) is a federal program that provides vaccine serums at no cost to providers for clients ages 0 through 18. All vaccines for this age group and for conditions covered by the VFC program must be obtained through the VFC program. The Division will not reimburse providers for the administration or purchase of privately purchased vaccines if the vaccine could have been obtained through the VFC program. For information about the VFC program or to enroll as a VFC provider, contact the Public Health Immunization Program. The Oregon VFC program website can be located at <http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/vfc/Pages/index.aspx> ¶¶

(6) The Division will only reimburse for the administration, not the serum, of vaccines available for free through the VFC Program. Refer to the 12/24/2013 Current Oregon Immunization Program State-Supplied Vaccine Billing Codes table available at <http://bit.ly/1c3T6zy> for a list of vaccines provided through the VFC Program. ¶¶

(7) To receive reimbursement for vaccine administration, VFC program providers must bill the Division: ¶¶

(a) With the appropriate vaccine common procedural terminology (CPT) code included; ¶¶

(b) Including the appropriate modifier -SL or -26; and ¶¶

(c) Reporting the vaccine administration in addition to an Evaluation and Management service (e.g., well-child visit) if provided on the same date of service; ¶¶

(8) For clients with private insurance, providers may bill the Division or the client's managed care or coordinated care organization (MCO/CCO) directly for the administration of VFC vaccines. Medicaid and CHIP are not considered the "payer of last resort" for administration of VFC vaccines. ¶¶

(9) In compliance with Section 1202 of the Affordable Care Act, VFC providers who qualify for the federal primary care rate increase as specified under 42 Code of Federal Regulation (CFR) 447 Subpart G (see also OAR 410-130-0005) are eligible for reimbursement for the administration of VFC vaccines at the Regional Maximum amount: ¶¶

(a) Effective 1/1/2013 the Regional Maximum amount is \$21.96. ¶¶

(b) For providers that have met the federal primary care definition, MCO and CCOs are required to reimburse the lessor of: ¶¶

(A) The Regional Maximum administration fee, or ¶¶

(B) Medicare 2014 RVU and 2009 conversion factor amount. ¶¶

(c) MCO and CCOs are not required to reimburse the Regional Maximum amount to providers that have not met the federal primary care definition but may at their option. ¶¶

(d) For all fee for service providers, the Division reimburses the Regional Maximum amount for the administration of VFC vaccines. ¶¶

(10) The Division covers immune globulins based on the OHA Prioritized List of Health Services. Synagis (palivizumab-rsv-igm) is covered with prior authorization only for high-risk infants and children. Refer to Guideline Note 69 of the ~~Health Evidence Review Commission's List of Prioritized~~ OHA Prioritized List of Health Services as referenced in OAR 410-141-053820, ~~<http://www.oregon.gov/OHA/HPA/CIS-HERC/Pages/Prioritized-List.aspx>~~ [web TBD] and Oregon Medicaid Fee-For-Service Prior Authorization Approval Criteria as referenced in 410-121-

0040, www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Medical-Surgical.aspx.¶

[ED. NOTE: Tables referenced are available from the agency.]

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-130-0368

RULE SUMMARY: Remove reference to a funding line on the Prioritized List. Update reference to the OHA Prioritized List. Update OAR reference to OAR 410-141-3830.

CHANGES TO RULE:

410-130-0368

Anesthesia Services ¶

- (1) Anesthesia is not covered for procedures that are ~~below the funding line on the Health Services Commission's not included on the OHA~~ Prioritized List of Health Services (see OAR 410-141-~~0523830~~ 3830). ¶
- (2) Effective January 1, 2012 all anesthesia claims submitted must be billed in minutes only. This includes; ¶
- (a) Claims for services provided prior to 1/1/12 that are submitted for the first time in 2012; ¶
- (b) Resubmitted unpaid claims for services provided prior to 1/1/12; and ¶
- (c) Adjustments made to claims for services performed prior to 1/1/12. Units must be converted by the provider from units to minutes. ¶
- (3) Qualifier MJ (indicating minutes) must be added to all claims; ¶
- (a) Claims with qualifier UN (indicating units) will be denied; and ¶
- (b) Claims without a qualifier will be denied. ¶
- (4) Reimbursement is based on the base units assigned to each anesthesia code listed in the current American Society of Anesthesiology Relative Value Guide plus one unit per each 15 minutes of anesthesia time, except for anesthesia for neuraxial labor analgesia/anesthesia/anesthesia (code 01967). See (5) below for reimbursement of neuraxial labor analgesia/anesthesia. ¶
- (a) The Division of Medical Assistance Programs (Division) will automatically calculate payment by adding the base units of the billed anesthesia code plus a unit per each 15 minutes of anesthesia time; ¶
- (b) Reimbursement will be made at a fraction of a unit for the last 1-14 minutes of anesthesia time; ¶
- (c) Do not add base units in addition to minutes. ¶
- (5) Anesthesia for neuraxial labor analgesia/anesthesia (code 01967) will be paid at a flat rate regardless of the units billed. ¶
- (6) Reimbursement for qualifying circumstances codes 99100-99140 and modifiers P1-P6 is bundled in the payment for codes 00100-01999. Do not add charges for 99100-99140 and modifiers P1-P6 in charges for 00100-01999. ¶
- (7) A valid consent form is required for all hysterectomies and sterilizations. ¶
- (8) If prior authorization (PA) was not obtained for a procedure that requires PA, then the anesthesia services may not be paid. Refer to OAR 410-130-0200 PA Table 130-0200-1. ¶
- (9) Anesthesia services are not payable to the provider performing the surgical procedure except for moderate (conscious) sedation. ¶
- (10) Moderate (conscious) sedation must be billed with codes 99143-99150. ¶
- [ED. NOTE: Tables referenced are available from the agency.]
- Statutory/Other Authority: ORS 413.042
- Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-130-0670

RULE SUMMARY: Remove reference to a "comfort care" line on the Prioritized List as it no longer exists.

CHANGES TO RULE:

410-130-0670

Death With Dignity ¶¶

(1) All Death with Dignity services must be billed directly to the Division of Medical Assistance Programs (Division), even if the client is in a managed care plan.¶¶

(2) Death with Dignity is a covered service, ~~incorporated in the "comfort care" condition/treatment line on the Health Services Commission's Prioritized List of Health Services.~~¶¶

(3) The following physician visits and medical encounters are billable when performed by a licensed physician or psychologist:¶¶

(a) The medical confirmation of the terminal condition;¶¶

(b) The two visits in which the client makes the oral request;¶¶

(c) The visit in which the written request is made;¶¶

(d) The visit in which the prescription is written;¶¶

(e) Counseling consultation(s); and¶¶

(f) Medication and dispensing.¶¶

(4) More than one of the services listed in sections (3)(a) through (3)(f) may be provided during the same visit. Additional visits for discussion or counseling are also covered for payment.¶¶

(5) Billing:¶¶

(a) All claims for Death with Dignity services must be made on a paper CMS-1500 billing form;¶¶

(b) Do not submit a claim for Death with Dignity services electronically or on an 837P;¶¶

(c) Claims must be submitted using appropriate CPT or HCPCS codes;¶¶

(d) The Division unique diagnosis code PAD-00 must be entered in Field 21 of the CMS-1500 billing form. Do not list any additional diagnosis codes in this field;¶¶

(e) Claims must be submitted only on paper to: 500 Summer Street NE E44, Salem, OR 97308;¶¶

(f) Prescriptions must be billed only with the Division unique code 8888-PAID-00. This code must be entered in Field 24D of the CMS-1500. In addition, the actual NDC number of the drug dispensed and the dosage must be listed below the prescription code;¶¶

(g) the Division may be billed for prescription services only when the pharmacy has been properly notified by the physician in accordance with OAR 847-015-0035. This OAR requires the physician to have the client's written consent to contact and inform the pharmacist of the purpose of the prescription.¶¶

[ED. NOTE: Forms referenced available from the agency.]

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-131-0040

RULE SUMMARY: Correct reference to lines on the Prioritized List. Update reference to the OHA Prioritized List. Update OAR reference to OAR 410-141-3830. Replace references to a "client" with "Member." Capitalize defined terms.

CHANGES TO RULE:

410-131-0040

Physical and Occupational Therapy ¶

(1) The Division's Physical and Occupational Therapy (PT/OT) Services rules are designed to assist licensed ~~Physical and Occupational~~ ~~Therapists~~ deliver health care services and prepare health claims for ~~client~~ Members with ~~Medical Assistance~~ ~~Program~~ coverage. The limits, authorization, and plan of treatment criteria apply to both rehabilitative and habilitative therapy. The definition for both is the following: ¶

(a) "Rehabilitative Services" means health care services that help an individual re-establish, restore, or improve skills and functioning for daily living that have been lost or impaired due to illness, injury, or disability; ¶

(b) "Habilitative Services" means health care services that help an individual keep, learn, or improve skills and functioning for daily living, designed to establish skills that have not yet been acquired at an age-appropriate level. Examples include therapy for a child who is not walking or talking at the expected age; ¶

(2) A total of 30 visits per year of ~~Rehabilitative~~ ~~Therapy~~ and a total of 30 visits per year of ~~Habilitative~~ ~~Therapy~~ (~~Physical and Occupational~~ ~~Therapy~~) are ~~included on these lines covered~~ when ~~Medically~~ Appropriate. ¶

Additional visits, not to exceed 30 visits per year of ~~Rehabilitative~~ ~~Therapy~~ and 30 visits per year of ~~Habilitative~~ ~~Therapy~~, may be authorized in cases of a new ~~Acute~~ injury, surgery, or other significant change in functional status. Children under age 21 may have additional visits authorized beyond these limits if ~~Medically~~ Appropriate, as per ~~Guideline~~ ~~Note 6 of the~~ OHA Prioritized List of Health Services. ¶

(3) OAR 410-131-0040 through 0160: ¶

(a) Apply to services delivered by ~~Home~~ ~~Health~~ ~~Agencies~~ and by hospital-based therapists in the outpatient setting. Billing and reimbursement for therapy services delivered by ~~Home~~ ~~Health~~ ~~Agencies~~ and ~~Hospital~~ outpatient departments must comply with the rules in their respective ~~Provider~~ guides; ¶

(b) Do not apply to services provided to ~~Hospital~~ inpatients; and ¶

(c) May not limit or effect any obligations of a school district or education entity eligible for reimbursement for covered, health-related services provided in support of a child with a disability education program required by state and federal law. School-sponsored services are supplemental to other health plan therapy services and are not considered duplicative. (See OAR chapter 410 division 133 SBHS rules for services provided by public education providers and OAR 410-141-3830-(Managed Care Entity (MCE) Billing and Payment). ¶

(4) The Division shall enroll only the following types of ~~Providers~~ as performing ~~Providers~~ under the PT/OT program: ¶

(a) An individual licensed by the relevant state licensing authority to practice ~~Physical~~ ~~Therapy~~; and ¶

(b) An individual licensed by the relevant state licensing authority to practice ~~Occupational~~ ~~Therapy~~. ¶

(5) All Division rules are intended to be used in addition to the ~~General Rules for Health Systems~~ Division programs (OAR chapter 410 division 120) and the Oregon Health Plan (OHP) (OAR chapter 410 division 141). ¶

(6) The ~~Oregon Health Evidence Review Commission's (HERC)~~ OHA Prioritized List of Health Services is found in OAR 410-141-~~0523830~~ and defines the covered services.

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.065

AMEND: 410-131-0080

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-131-0080

Therapy Plan of Care and Record Requirements ¶¶

- (1) There must be a rehabilitative or habilitative therapy plan of care to receive payment.¶¶
- (2) The Division shall authorize for the level of care or type of service that meets the client's medical need consistent with the ~~Health Evidence Review Commission's (HERC)~~OHA Prioritized List of Health Services (OHA Prioritized List) and guideline notes.¶¶
- (3) The rehabilitative or habilitative therapy plan must adhere to the licensing board requirements of care and shall include:¶¶
 - (a) Client's name, ICD diagnosis code, and type, amount, frequency, and duration of the proposed rehabilitative or habilitative therapy;¶¶
 - (b) Individualized, measurably objective functional goals;¶¶
 - (c) Documented need for extended service, considering 60 minutes as the maximum length of a treatment session;¶¶
 - (d) Plan to address implementation of a home management program as appropriate from the initiation of therapy forward;¶¶
 - (e) Dated signature of the therapist or the prescribing practitioner establishing the therapy plan of care; and¶¶
 - (f) For home health clients, any additional requirements included in OAR chapter 410 division 127.¶¶
- (4) The therapy treatment plan and regimen shall be taught to the client, family, foster parents, or caregiver during the therapy treatments. The client must be present for demonstrating therapy during teaching to assure therapy regimen is performed safely and correctly. The division may not authorize extra treatments for teaching.¶¶
- (5) A therapy plan must comply with the relevant state licensing authority's standards.¶¶
- (6) If a state licensing authority has not adopted therapy plan of care standards, the therapy plan of care shall include:¶¶
 - (a) The need for continuing rehabilitative or habilitative therapy clearly stated;¶¶
 - (b) Changes to the rehabilitative or habilitative therapy plan of care, including changes to duration and frequency of intervention; and¶¶
 - (c) Any changes or modifications to the therapy plan of care shall be documented, signed, and dated by the prescribing practitioner or therapist who developed the plan.¶¶
- (7) Therapy records shall include:¶¶
 - (a) A written referral, including:¶¶
 - (A) The client's name;¶¶
 - (B) The ICD-10-CM diagnosis code; and¶¶
 - (C) Specification of the type of services, amount, and duration required.¶¶
 - (b) A copy of the signed therapy plan of care must be on file in the provider's therapy record prior to billing for services;¶¶
 - (c) Documents, evaluations, re-evaluations, and progress notes to support the rehabilitative or habilitative therapy treatment plan and prescribing provider's written orders for changes in the therapy treatment plan;¶¶
 - (d) Modalities used on each date of service;¶¶
 - (e) Procedures performed, and amount of time spent performing the procedures, documented and signed by the therapist; and¶¶
 - (f) Documentation of splint fabrication and time spent fabricating the splint.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 688.135, 414.065

RULE SUMMARY: Remove reference to a funding line on the Prioritized List. Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-131-0120

Limitations of Coverage and Payment ¶¶

- (1) The provision of PT/OT evaluations and therapy services require a prescribing ~~p~~Practitioner referral, and services shall be supported by a therapy plan of care signed and dated by the prescribing ~~p~~Practitioner as specified in 42 CFR 440.110. ¶¶
- (2) PT/OT initial evaluations and re-evaluations do not require PA and are not subject to prepayment review (PPR), but are limited to the following: ¶¶
- (a) Up to two initial evaluations in any 12-month period; and ¶¶
- (b) Up to four re-evaluation services in any 12-month period. ¶¶
- (3) Reimbursement is limited to the initial evaluation when both the initial evaluation and a re-evaluation are provided on the same day. ¶¶
- (4) School-sponsored therapy services are considered supplemental to other plan-covered therapy services that the student receives. School-based therapy services may not apply toward the ~~client~~Member's maximum therapy allowances. (See OAR chapter 410, division 133 SBHS rules.) ¶¶
- (5) All other ~~e~~Occupational and ~~p~~Physical ~~t~~Therapy treatments are subject to PPR and require PA following 30 visits in a calendar year. See OAR 410-131-0160. ¶¶
- (6) A licensed ~~e~~Occupational or ~~p~~Physical ~~t~~Therapist or a licensed ~~e~~Occupational or ~~p~~Physical ~~t~~Therapy assistant under the supervision of a therapist shall be in constant attendance while therapy treatments are performed: ¶¶
- (a) Rehabilitative and habilitative therapy treatments may not exceed one hour per day each for ~~e~~Occupational and ~~p~~Physical ~~t~~Therapy; ¶¶
- (b) Modalities: ¶¶
- (A) Are subject to PPR and require PA following 30 habilitative and 30 rehabilitative visits in a calendar year; ¶¶
- (B) Up to two modalities may be authorized on the day of treatment; ¶¶
- (C) Need to be billed in conjunction with a therapeutic procedure code, excluding procedure code S8940; and ¶¶
- (D) Each individual supervised modality code may be reported only once for each ~~client~~Member encounter. ¶¶
- (c) Massage therapy is limited to two units per day of treatment and shall be authorized only in conjunction with another therapeutic procedure or modality. ¶¶
- (7) Supplies and materials for the fabrication of splints shall be billed at the ~~a~~Acquisition ~~e~~Cost, and reimbursement may not exceed the Division's maximum allowable in accordance with the physician fee schedule. Acquisition ~~e~~Cost is purchase price plus shipping. Off-the-shelf splints, even when modified, are not included in this service. ¶¶
- (8) The following services are not covered under this rule: ¶¶
- (a) Services not ~~m~~Medically ~~a~~Appropriate; ¶¶
- (b) Services that are not paired with a ~~funded~~ diagnosis on the ~~HERCs~~OHA Prioritized List pursuant to OARs 410-141-3820 and 410-141-3830; ¶¶
- (c) Work hardening; ¶¶
- (d) Back school and back education classes; ¶¶
- (e) Services included in OAR 410-120-1200 (Excluded Services Limitations); ¶¶
- (f) Durable ~~m~~Medical ~~e~~Equipment and medical supplies other than the following splint supplies: ¶¶
- (A) Application of splints: ¶¶
- (i) 29105 Application of long arm splint (shoulder to hand); ¶¶
- (ii) 29125 Application of non-moveable, short arm splint (forearm to hand); ¶¶
- (iii) 29126 Application of moveable, hinged short arm splint (forearm to hand); ¶¶
- (iv) 29130 Application of non-moveable, hinged finger splint; ¶¶
- (v) 29131 Application of moveable, hinged finger splint. ¶¶
- (B) Supplies to create splints: ¶¶
- (i) Q4017 Cast supplies, long arm splint, adult (11 years +), plaster; ¶¶
- (ii) Q4018 Cast supplies, long arm splint, adult (11 years +), fiberglass; ¶¶
- (iii) Q4019 Cast supplies, long arm splint, pediatric (0-10 years), plaster; ¶¶
- (iv) Q4020 Cast supplies, long arm splint, pediatric (0-10 years), fiberglass; ¶¶
- (v) Q4021 Cast supplies, short arm splint, adult (11 years +), plaster; ¶¶
- (vi) Q4022 Cast supplies, short arm splint, adult (11 years +), fiberglass; ¶¶

(vii) Q4023 Cast supplies, short arm splint, pediatric (0-10 years), plaster;_¶

(viii) Q4024 Cast supplies, short arm splint, pediatric (0-10 years), fiberglass;_¶

(ix) Q4049 Finger splint, static;_¶

(x) Q4051 Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and other supplies);_¶

(9) Physical capacity examinations are not a part of the PT/OT program but may be reimbursed as administrative examinations when ordered by the local branch office. See OAR chapter 410, division 150 for information on administrative examinations and report billing.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Remove reference to a funding line on the Prioritized List. Update reference to the OHA Prioritized List. Update OAR reference to OAR 410-141-3830. Replace references to a "member" with "CCO Member." Capitalize defined terms.

CHANGES TO RULE:

410-131-0160

Prepayment Review (PPR) and Prior Authorization (PA) for Payment ¶

(1) Most ~~OHP client~~ Members have prepaid health services contracted for by the Authority through enrollment in a ~~Managed Care Entity (MCE)~~ Coordinated Care Entity (MCE Organization (CCO)). ¶

(2) The ~~provider~~ shall verify whether an ~~MCE CCO~~ or the Division is responsible for reimbursement. Refer to OAR 410-120-1140 Verification of Eligibility and Coverage. ¶

(3) ~~If a client is enrolled in an MCE~~ For CCO Members, there may be PA requirements for some services that are provided through the ~~MCE CCO~~. Providers shall comply with the ~~MCE CCO's~~ PA requirements or other policies necessary for reimbursement from the ~~MCE CCO~~ before providing services to any ~~OHP client enrolled in an MCE CCO Member~~. The ~~physical or occupational~~ Therapy (PT/OT) ~~provider~~ shall contact the ~~client's~~ MCE applicable CCO for specific instructions. ¶

(4) A PT/OT ~~provider~~ assumes full financial risk in providing services to a ~~FFS client~~ Open Card Member in providing services that are not in compliance with Oregon Administrative Rules. See also OAR 410-120-1320 Authorization of Payment. ¶

(a) PT/OT initial evaluations and re-evaluations are not subject to prepayment review (PPR) and do not require a PA; ¶

(b) To ensure reimbursement of PT/OT services and procedures ~~beyond the initial evaluation~~, the PT/OT ~~provider~~ must submit all required supporting documentation; ¶

(A) Upon submission of the first claim in a series of claims in each therapy plan of care as established by prescribing ~~practitioner~~ per OAR 410-131-0080 for claims subject to PPR; ¶

(B) Request a PA within five (5) working days following 30 rehabilitative or 30 habilitative visits within a calendar year if additional visits are necessary; ¶

(i) PA requests dated within five (5) working days may be approved retroactively to include services provided within five (5) days prior to the date of the PA request; ¶

(ii) PA requests dated beyond five (5) working days may not be authorized retroactively and if authorized shall be effective the date of the PA request. The Division recognizes the facsimile or postmark as the PA date of request. ¶

(c) All claims subject to PPR or that require PA must include a therapy plan of care; and ¶

(d) A PA is not required for Medicare-covered PT/OT services provided to dual-eligible ~~client~~ Members (Medicare clients who are also Medicaid-eligible). ¶

(5) If the service or item is subject to PPR or requiring PA, the PT/OT ~~provider~~ shall follow and comply with PPR and PA requirements in these rules and the ~~General Rules~~, (OAR chapter 410, division 120) including but not limited to: ¶

(a) The service is adequately documented (see OAR 410-120-1360 Requirements for Financial, Clinical and Other Records). Providers shall maintain documentation in the ~~provider's~~ files to adequately determine the type, ~~medical~~ Appropriateness, or quantity of services provided; ¶

(b) The services provided are consistent with the information submitted when authorization was requested; ¶

(c) The services billed are consistent with those services provided; ¶

(d) The services are provided within the timeframe specified on the authorization of payment document; and ¶

(e) Includes the PA number on all claims for ~~occupational and physical~~ Therapy services that require PA, or the Division shall deny the claim. ¶

(6) The following services are subject to PPR when paired ~~above the funding line on the HERC~~ OHA Prioritized List (see OAR 410-141-3830) if visits have not exceeded the allowed 30 habilitative and 30 rehabilitative visits allowed in a calendar year: ¶

(a) 95831 Manual muscle testing of arm, leg or trunk; ¶

(b) 95832 Manual muscle testing of hand; ¶

(c) ~~95833~~ Manual muscle testing of whole body; ¶

(d) 95834 Manual muscle testing of whole body including hands; ¶

(e) 95851 Range of motion testing of arm, leg or each spine section; ¶

(f) 95852 Range of motion testing of hand; ¶

(g) 97012 Application of mechanical traction to ~~one~~ (1) or more areas; ¶

- (h) 97022 Application of whirlpool therapy to ~~4~~one (1) or more areas;¶
 - (i) 97036 Physical ~~t~~herapy treatment to ~~4~~one (1) or more areas, Hubbard tank, each 15 minutes;¶
 - (j) 97110 Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes;¶
 - (k) 97112 Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes;¶
 - (~~l~~) 97113 Water pool therapy with therapeutic exercises to ~~4~~one (1) or more areas, each 15 minutes;¶
 - (m) 97116 Walking training to ~~4~~one (1) or more areas, each 15 minutes;¶
 - (n) 97124 Therapeutic massage to ~~4~~one (1) or more areas, each 15 minutes;¶
 - (o) 97140 Manual (physical) therapy techniques to ~~4~~one (1) or more regions, each 15 minutes;¶
 - (p) 97150 Therapeutic procedures in a group setting (~~4~~one visit = ~~4~~one unit);¶
 - (q) 97530 Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes;¶
 - (r) 97532 Development of cognitive skills to improve attention, memory, or problem solving, each 15 minutes;¶
 - (s) 97535 Self-care or home management training, each 15 minutes;¶
 - (t) 97542 Wheelchair management, each 15 minutes;¶
 - (u) 97755 Assistive technology assessment to enhance functional performance, each 15 minutes; and¶
 - (v) 97761 Training in use of prosthesis for arms and/or legs, per 15 minutes. ¶
- (7) PA is required when:¶
- (a) There is documented need for extended service, considering 60 minutes as the maximum length of a treatment session;¶
 - (b) There is documented need for continuing rehabilitative or habilitative therapy, considering 30 habilitative and 30 rehabilitative visits in a calendar year.¶
 - (c) Requesting services for treatments that ~~are below the funded line~~do not pair on the OHA Prioritized List or ~~not~~are otherwise excluded from coverage per OAR 410-141-38205.
- Statutory/Other Authority: ORS 413.042
 Statutes/Other Implemented: ORS 414.025, ORS 414.065

RULE SUMMARY: Update reference to the OHA Prioritized List. Revise definition of the Prioritized List of Health Services, including addition of definition for the OHA Prioritized List.

CHANGES TO RULE:

410-133-0040

Definitions ¶¶

In addition to the definitions in OAR 410-120-0000 and OAR 410-141-0001, the following definitions apply to these rules:¶¶

- (1) "Adapted vehicle" means a vehicle that has been physically adjusted or designed to meet the needs of the individual student under IDEA (e.g., special harnesses, wheelchair lifts, ramps, specialized environmental controls, etc.) to accommodate students with disabilities. Special physical adaptations may also include air conditioning and specialized suspension systems.¶¶
- (2) "Assessment" means an SBHS-recognized provider's process of obtaining information regarding an individual's health status. Assessment is process-oriented, focusing on measuring an individual's abilities and providing feedback for improvement.¶¶
- (3) "Assistive technology" means any item, piece of equipment, software program, or product that is used to increase, maintain, or improve functional capabilities to aid an individual with disabilities or functional limitations to perform tasks.¶¶
- (4) "Behavioral health" has the same meaning as defined in OAR 410-172-0600.¶¶
- (5) "Behavioral health supports" means a broad range of mental health wellness supports for students with social and/or relational health needs. Supports may include social skills training or groups, regular check-ins with school staff, development of behavior intervention plans, substance use prevention groups, supporting essential health and well-being needs (such as food insecurity or housing), referral to treatment, and/or coordination with community providers.¶¶
- (6) "Behavioral health treatment" means intensive services for children or young adults with identified mental health or substance use needs. Treatment may include therapeutic interventions such as individual or family therapy sessions, intensive treatment groups related to specific mental health or substance use needs, or risk assessments and safety planning for students experiencing suicidal ideation or other acute behavioral health crises.¶¶
- (7) "Care coordination" means the act and responsibility to deliberately organize culturally and linguistically appropriate services, care activities, and information sharing among all participants involved with a child or young adult's care according to their physical, developmental, behavioral, dental and social needs. Care coordination involves organizing care activities, sharing information, and consultation to ensure and deliver safe and effective care aligned with the child or young adult's needs. Care coordination includes but is not limited to training and supervision and communicating and sharing information with the child or young adult's parent/guardian, physician, community practitioner(s), community organization(s), coordinated care organization (CCO), and staff.¶¶
- (8) "Case Management Services" means services provided to ensure a child or young adult obtains health services necessary to maintain physical, behavioral, and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, behavioral, or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, behavioral, or dental services, referring members to community services and supports.¶¶
- (9) "Centers for Medicare and Medicaid Services (CMS)" means the federal regulatory agency for Medical Assistance Programs, including Medicaid.¶¶
- (10) "Child or young adult" means an individual from birth through the school year in which they turn 21.¶¶
- (11) "Delegation process" has the same meaning as defined in OAR 851-006-0011. The delegation process must be completed in compliance with OAR Chapter 851, Division 47 Standards for Registered Nurse Delegation Process.¶¶
- (12) "Diagnosis code" has the same meaning as defined in OAR 410-120-0000.¶¶
- (13) "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" has the same meaning as defined in OAR 410-120-0000.¶¶
- (14) "Early Intervention/Early Childhood Special Education (EI/ECSE)" has the same meaning as defined in OAR 581-015-2000.¶¶
- (15) "Education agency" means, for the purposes of these rules, a public school district, EI/ECSE contractor or subcontractor, education service district, or a state institution providing educational services or transition services (defined in OAR Chapter 581, Division 15) to children and young adults that receives state or federal funds either directly or by contract or subcontract with the Oregon Department of Education (ODE). The ODE is considered a

local unit of government pursuant to 42CFR 433.51.¶¶

(16) "Education service district (ESD)" means a district created under ORS 334.010 that provides regional educational services to component school districts.¶¶

(17) "Evaluation" means an objective examination of an individual's health status based upon well-defined criteria to inform health-related needs or diagnosis or for the purpose of planning treatment. See also re-evaluation services.¶¶

(18) "Federal Medical Assistance Percentage (FMAP)" means the federal government's share of expenditures for the Medicaid and Children's Health Insurance Program (CHIP) programs.¶¶

(19) "Health Evidence Review Commission (HERC)" has the same meaning as defined in OAR 410-120-0000.¶¶

(20) "Health Insurance Portability and Accountability Act of 1996 (HIPAA)" means the federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information.¶¶

(21) "Individual Plan of Care (IPOC)" means a prescriptive document for billing Medicaid for planned services provided to a child or young adult in education settings. To serve as the prescriptive document the plan must include the education agency's name, the specific child or young adult's first and last name, and each necessary and appropriate health service category including the nature, extent, or units of service and therapeutic value for each service. The IPOC may be an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) or any other established and documented individualized health or behavioral health plan if such document contains the necessary, prescriptive elements required to serve as the prescriptive document for billing Medicaid.¶¶

(22) "Individuals with Disabilities Education Act (IDEA) of 1975" means the federal law ensuring the rights of children with disabilities to a free and appropriate public education (FAPE).¶¶

(23) "Individualized Education Program (IEP)" has the same meaning as defined in 34 CFR 300.320.¶¶

(24) "Individualized Family Service Plan (IFSP)" has the same meaning as defined in 34 CFR 303.320.¶¶

(25) "Medicaid" has the same meaning as defined in OAR 410-120-0000.¶¶

(26) "Medicaid-enrolled" means an individual member or provider who is enrolled in Oregon's Medicaid Program.¶¶

(27) "Medicaid Management Information System (MMIS)" means a statewide system that houses Medicaid data necessary for the business operations of Medicaid administration including, but not limited to, eligible member information, enrolled provider information, procedure and diagnosis codes, and claims data.¶¶

(28) "Medically Appropriate" has the same meaning as "EPSDT Medically Appropriate" in OAR 410-151-0001.¶¶

(29) "Medically Necessary" has the same meaning as "EPSDT Medically Necessary" in OAR 410-151-0001.¶¶

(30) "MMIS Provider Web Portal" means an electronic portal that allows Oregon Medicaid enrolled providers to log in and access relevant information to provide and be reimbursed for services provided to Oregon's Medicaid-enrolled members. Medicaid-enrolled providers can use the portal to verify member eligibility and managed care assignment, access and query ~~Oregon's HERC~~ the OHA Prioritized List of Health Services, submit and adjust claims for services provided, download claim remittance advices, and more. Non-enrolled providers can apply through the portal to enroll as an Oregon Medicaid provider.¶¶

(31) "National Provider Identifier (NPI)" has the same meaning as defined in OAR 410-120-0000.¶¶

(32) "Non-Billing Provider" has the same meaning as defined in OAR 410-120-0000.¶¶

(33) "OHA Prioritized List of Health Services" has the same meaning as defined in OAR 410-120-0000.¶¶

(34) "Oregon Department of Education (ODE)" means the state agency that provides oversight to public education agencies for ensuring compliance with federal and state laws relating to education.¶¶

(34) "Oregon Health Authority (Authority)" has the same meaning as defined in OAR 410-120-0000.¶¶

(35) "Oregon Health Plan (OHP)" has the same meaning as defined in OAR 410-120-0000.¶¶

(36) "Personal care services" means the provision of, assistance with, or cueing for functional activities, physical or behavioral, that a child or young adult requires for their continued well-being. Personal care services include, but are not limited to, ambulation, mobility, transfers, and positioning, basic personal hygiene, continence/incontinence care, nutrition and feeding, medication management (including administration), redirection and intervention for behavior, and trained, assigned, or delegated services, including delegated nursing procedures. Personal care services are planned services included in an IPOC and deemed medically necessary and appropriate by a supervisory-level, SBHS-recognized provider within their scope of practice.¶¶

(37) "Planned services" means school-based health services that are provided pursuant to an IPOC. See also unplanned services.¶¶

(38) "Practitioner" means an individual licensed under state law to engage in the provision of health care services within the scope of the practitioner's license or certification, including a health care practitioner' a licensed health care practitioner' or a practitioner of the healing arts.¶¶

~~(39) "Prioritized List of Health Services" has the same meaning as defined in OAR 410-120-0000.¶¶~~

(40) "Procedure code" means a code or codes used in the Healthcare Common Procedural Coding System (HCPCS) or Current Dental Terminology (CDT).¶¶

(41) "Re-evaluation" means an objective examination completed after an initial evaluation that focuses on the

overall effectiveness of the current treatment, including progress toward current goals, modifying goals or treatment, or making a professional judgment to determine whether or not the child or young adult shall continue to receive one or more health-related services. Continuous monitoring of the child or young adult's progress as a component of ongoing therapy services is not billable as a re-evaluation.¶¶

(42) "Referral" means the direction of an individual, based on the individual's clinical needs and personal choice, to a facility or practitioner for a diagnostic test or health care treatment or service.¶¶

(43) "SBHS Documentation" means the combination of required information to bill direct services under the SBHS program including, but not limited to, service documentation and the Individual Plan of Care (IPOC), when applicable.¶¶

(44) "School medical provider" means an enrolled provider type that is established by the Authority to designate the provider eligible to receive Medicaid reimbursement for Medicaid-covered school-based health services. Authority-enrolled education agencies, as defined in this rule, are school medical providers.¶¶

(45) "Section 504 of The Rehabilitation Act of 1973" means a federal civil rights law, guided by the Americans with Disabilities Act (ADA), that protects qualified individuals from discrimination based on their disability.¶¶

(46) "Section 504 Accommodation Plan" means a formal plan that provides children and young adults with disabilities specific supports and accommodations needed to access the general education setting.¶¶

(47) "Specialized transportation" means transportation to a medically necessary service (as outlined in the IEP/IFSP of a Medicaid-enrolled child) provided in a specially adapted vehicle. In all cases, the medical need for physical or environmental adaptations during transport from home to school and back home must be identified in the IEP/IFSP.¶¶

(48) "Supervisory-level" means the SBHS-recognized provider is licensed or certified to practice independently and may supervise or train other SBHS-recognized providers.¶¶

(49) "Teacher Standards and Practices Commission (TSPC)" means the commission that governs licensing of teachers, personnel, service specialists, and administrators as set forth in OAR Chapter 584.¶¶

(50) "Transportation vehicle trip log" means a record or log kept specifically for tracking each transportation trip to or from a Medicaid-covered health service a Medicaid-eligible child or young adult receives.¶¶

(51) "Treatment Plan" means a licensed healthcare practitioner's written plan of health services, including treatment with proposed location, frequency, and duration of treatment. A treatment plan must be written by a licensed healthcare practitioner within the scope of the practitioner's license or certification and in compliance with the practitioner's respective Oregon board. Treatment plans may include but are not limited to behavioral health service plans (see OAR 309-019-0140), a registered nurse's plan of care (see Oregon's Nurse Practice Act, OARs Chapter 851), occupational therapy service plans (See OARs Chapter 339, Division 10), and physical therapy plans of care (see OARs Chapter 848, Division 40).¶¶

(52) "Unit" means a service measurement for billing and reimbursement efficiency.¶¶

(53) "Unplanned services" means the services and interventions that are urgent or immediate in nature and typically provided outside of services specified on an IPOC. Unplanned services may or may not lead to establishing an IPOC. See also planned services.¶¶

(54) "Unregulated Assistive Person (UAP)" has the same meaning as defined in OAR 851-006-0011.¶¶

(55) "Visit" means a service measurement of time for billing and reimbursement efficiency. For billing purposes, a visit is always presented as one (1) visit.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

AMEND: 410-133-0060

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-133-0060

School-Based Health Services ¶¶

(1) School-based health services are provided in education settings in support of a child or young adult's education to address health-related service needs and devices that help the individual child or young adult keep, learn, or improve skills and functioning that adversely affect individual educational performance.¶¶

(2) Education agencies may be reimbursed for the following services subject to the requirements in OAR 410-133-0080 and 410-133-0090.¶¶

(a) Evaluations, re-evaluations, and assessments;¶¶

(b) Care coordination and referrals;¶¶

(c) Direct assistance with selection, acquisition, or use of assistive technology;¶¶

(d) Audiology services;¶¶

(e) Behavioral health services;¶¶

(f) Dental services;¶¶

(g) Diagnostic, screening, preventive, and rehabilitative services as set out in 42 CFR 440.130;¶¶

(h) Nursing services;¶¶

(i) Nurse Practitioner services;¶¶

(j) Occupational therapy services;¶¶

(k) Personal care services;¶¶

(l) Physical therapy services;¶¶

(m) Physician services;¶¶

(n) Specialized transportation services; and¶¶

(o) Speech-language pathology services.¶¶

(3) Medicaid-covered services provided to children and young adults ages 0-21 are not subject to ~~Oregon's Medicaid program's HERC~~the OHA Prioritized List of Health Services.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Remove reference to a funding line on the Prioritized List. Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-136-3000

Responsibility for Providing Non-emergent Medical Transportation ¶¶

(1) The Authority shall provide non-emergent medical transportation (NEMT) for eligible clients who receive their Oregon Health Plan (OHP) covered medical services on a fee-for-service basis or are clients enrolled in coordinated care organizations (CCO), and for eligible clients who receive Reproductive Health Access Fund (RHAF) covered services. The Authority shall discontinue providing this service to a client enrolled in a CCO after the date the client is enrolled in a CCO. The CCO shall provide and coordinate the service to their enrollees on and after the date of the client's enrollment in the CCO pursuant to section (2) of this rule. ¶¶

(2) When a CCO begins providing NEMT services for its enrollees, the Authority shall provide NEMT services in the CCO's service area only to clients not enrolled in a CCO. ¶¶

(a) The Authority may not pay for services covered by a CCO. Reimbursement is a matter between the CCO and its transportation brokerage and subcontractor. Reimbursement is a matter between the CCO and its contracted brokerage and transportation providers. ¶¶

(b) For clients enrolled in a CCO the transportation provider must coordinate all transportation services with the client's transportation brokerage or CCO prior to providing services. ¶¶

(3) The requirements in OAR 410-136-3000-410-136-3360 apply to NEMT services for which the Authority is responsible pursuant to this rule. ¶¶

(4) Brokerages shall, and must ensure subcontractors, have access to culturally and linguistically appropriate tools available to provide clients accessing NEMT services. ¶¶

(a) of free written translations, oral interpretation, certified and qualified spoken and sign language interpreters, alternative formats, and auxiliary aids and services, for the client to be able to understand NEMT services information provided. ¶¶

(b) Alternative formats or languages, including interpretation during phone calls, shall be provided upon request at no cost to the client. ¶¶

(5) Language access services for NEMT services also applies to client representatives, family members and caregivers with hearing impairments or Limited English Proficiency (LEP) who need to understand the client's condition and care. For OHP members, see Oregon Health Plan (OHP) program OAR 410-120-0001 Interpreter Services requirements for Medicaid members with Limited English Proficiency services. For RHAF clients, see Certification Requirements for RHCare Clinics Version 3, Certification Requirements for CCare Clinics Version 2, or Certification Requirements for AbortionCare Clinics Version 3 for language access requirements adopted in in OAR 333-004-3030, which are incorporated by reference in this section. ¶¶

(6) A brokerage may request that the Authority delay responsibility for reimbursement to clients pursuant to OAR 410-136-3240, Client Reimbursed Mileage, Meals and Lodging, until a CCO in the brokerage's service area assumes NEMT services for the CCO's enrolled client. Any delay of responsibility must not exceed fourteen (14) days and must be prior approved by the Authority. The delay of the brokerage's responsibility also includes reimbursing clients in the fee-for-service delivery system. ¶¶

(7) OAR 410-136-3040, Vehicle Equipment and Subcontractor Standards and OAR 410-136-3120, Secured Transports do not apply to ambulance providers, ambulance vehicles, or ambulance personnel that are licensed and regulated by ORS Chapter 682 and OAR chapter 333, divisions 250, 255, 260 and 265, whether providing ambulance or stretcher transports. ¶¶

(8) The following definitions specifically apply to OAR 410, division 136. This rule does not include an exhaustive list of Division acronyms and definitions. For more information of any terms not defined in this rule, see Oregon Health Plan (OHP) program OAR 410-141-3500 Acronyms and Definitions; OAR 410-120-0000 Acronyms and Definitions; OAR 309-032-0860; OAR 410-200-0015 General Definitions; and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 411, 413, or 461 administrative rules; or contact the Division. For purposes of the rules OAR 410-136-3000 through 410-136-3360. ¶¶

(a) "Attendant" means an individual at least 18 years of age to accompany the client. An attendant may also be a behavioral health personal care attendant allowed to accompany the client in accordance with OAR 410-172-0780. ¶¶

(b) "Brokerage" means a governmental transportation brokerage (local unit of government), or other entity,

enrolled by and contracted with the Authority to arrange rides and pay subcontractors for NEMT services; ¶

(c) "Client" means an individual eligible to receive OHP or RHAF health services on the date of service and who resides in the Service Area; ¶

(d) "Contractor" means a transportation brokerage, or other entity, enrolled as an OHP provider by and contracted with the Authority to arrange rides brokerages pay subcontractors for NEMT services; ¶

(e) "Covered service" means medically necessary and appropriate health services and items described in ORS Chapter 414 and applicable administrative rules and the OHA Prioritized List of Health Services ~~above the funding line set by the legislature~~, consistent with OAR Chapter 410 division 120, or services as described in OAR 333-004-3070; ¶

(f) "Electronic Data Interchange (EDI)" means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions consistent with OAR Chapter 410 division 120; ¶

(g) "Local area" means an area within the accepted community standard and includes the client's metropolitan area, city, or town of residence; ¶

(h) "Member" means an Oregon Health Plan (OHP) client enrolled with a coordinated care organization (CCO); ¶

(i) "Non-Emergent Medical Transportation Services (NEMT)" means transportation to or from a source of covered service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000 and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available; ¶

(j) "Provider" means a public Agency, non-profit company, for-profit company, or an individual with whom a brokerage subcontracts with to provide rides; ¶

(k) "RHAF" means Reproductive Health Access Fund, a source of coverage for reproductive health services as defined in OAR 333-004-3070 provided to individuals who complete the RH Access Fund Enrollment Form and are deemed eligible ("RHAF client"); ¶

~~(L)~~ "RH Access Fund Eligibility Database" means the centralized, web-based data system operated by the RH Program to house information about enrollees; ¶

(m) "Ride" means to drive the client to and from Oregon Health Plan (OHP) covered services or RHAF covered services; ¶

(n) "Secure transport" means NEMT services for the involuntary transport of clients who are in danger of harming themselves or other individuals; ¶

(o) "Service area" means the geographic area within which the Regional Brokerage agreed under contract with the Authority to provide Rides as a service through the contractor's Call Center; ¶

(p) "Subcontractor" means the provider, individual or entity, with which the brokerage executes a contract to drive the client to and from Oregon Health Plan (OHP) covered services; ¶

(q) "The Authority" means the Oregon Health Authority (OHA); ¶

(r) "Volunteer" (for the purposes of NEMT) means an individual selected, trained and under the supervision of the ODHS who is providing services on behalf of the ODHS in a non-paid capacity except for incidental expense reimbursement under the ODHS Volunteer Program authorized by ORS 409.360.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Add the definition for the OHA Prioritized List, referencing OAR 410-120-0000.

CHANGES TO RULE:

410-140-0010

Definitions and Acronyms

- (1) Aphakia is a condition in which the eye lens of one or both eyes are missing.¶
- (2) Comorbidity has the meaning provided in OAR 410-141-3820 (10 & 11).¶
- (3) Congenital aphakia is a congenital eye defect presenting at birth with no lens formation.¶
- (4) Contractor is SWEEP Optical Laboratories, providing vision materials and supplies for OHP members with FFS coverage (refer to OAR 410-140-0400).¶
- (5) "Coordinated Care Organization (CCO)" has the meaning as provided in OAR 410-141-3500. A CCO is a Managed Care Entity for its managed care contract(s) with the Authority, without regard to whether the contract(s) involves federal funds or state funds or both.¶
- (6) "Covered Services" has the meaning as provided in OAR 410-120-0000.¶
- (7) "Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services" means the federally mandated comprehensive and preventative child health program for individuals under the age of 21, under the Omnibus Budget Reconciliation Act of 1989 and Section 1905(r)(5) of the Social Security Act. Consistent with state and federal law and regulations, the OHP Dental Program ensures that all dentally necessary services and screenings are provided, either directly or through an Authority contracted MCE for EPSDT covered services (Chapter 410, Division 151).¶
- (8) "Fraud" has the meaning as provided in OAR 410-120-0000.¶
- (9) "Health Care Interpreter (HCI)" means an individual who has been approved and certified by the Authority under ORS 413.558 to accurately interpret oral statements and documents to a person with limited English proficiency or in sign language. Qualified Health Care Interpreter has the same meaning.¶
- (10) Health Evidence Review Commission (HERC) has the meaning provided in OAR 410-120-0000.¶
- (11) "Interpreter Services" means services available to those with Limited English Proficiency (LEP) as described in Title VI of the Civil Rights Act of 1964; Section 1557 of the Affordable Care Act; and ORS 413.550 for Meaningful Language Access Interpreter services may also be accessed for deaf or hard of hearing members to ensure effective communication, as required by the Americans with Disabilities Act. The interpreter shall be a certified or qualified health care interpreter (HCI).¶
- (12) Keratoconus is an eye condition in which your cornea gets thinner and gradually bulges outward into a cone shape.¶
- (13) Managed Care Entity (MCE) has the meaning provided in OAR 410-120-0000.¶
- (14) "Medicaid Division" (Division) has the meaning as provided in OAR 410-120-0000 and is within the Authority. The Division is responsible for managing the Oregon Health Plan (OHP), which is Oregon's Medicaid program.¶
- (15) Ocular prosthesis has the meaning as provided in OAR 410-122-0010.¶
- (16) "OHA Prioritized List of Health Services" (OHA Prioritized List) has the meaning provided in OAR 410-120-0000.¶
- ~~(17)~~ Ophthalmologist is a specialist in the study and treatment of disorders and diseases of the eye.¶
- ~~(178)~~ Optometrist has the meaning provided in OAR 410-120-0000.¶
- ~~(189)~~ Optometric services has the meaning provided in OAR 410-120-0000.¶
- ~~(1920)~~ Oregon Health Authority (Authority) has the meaning provided in OAR 410-120-0000.¶
- ~~(201)~~ Oregon Health Plan (OHP) has the meaning provided in OAR 410-120-0000 and OAR 410-141-3500.¶
- ~~(242)~~ "Prescription" means the definition provided in OAR 410-121-0144.¶
- ~~(22) "Prioritized List of Health Services" (Prioritized list) means the comprehensive list of health services, ranked by priority. The Oregon Health Plan benefits are made from The List and determined by the Oregon Legislature.¶~~
- (23) Pseudophakia is a term used for placing an artificial lens into the eye. Also referred to as intraocular, "fake lenses" or lens implants.¶
- (24) Refraction determination is testing performed by an optometrist or ophthalmologist to determine refractive error in vision causing nearsightedness, farsightedness, or astigmatism.¶
- (25) The Division of Medical Assistance Programs (Division) has the meaning provided in OAR 410-120-0000.¶
- (26) Third-Party Liability (TPL) has the meaning provided in OAR 410-120-0000.¶
- (27) "Vision Services" refer to services provided by an optometrist or ophthalmologist.

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: 414.065, 414.025, 414.075

RULE SUMMARY: Remove reference to covered diagnoses, as all diagnoses on Prioritized List will now be covered. Remove reference to the comorbidity rule in OAR 410-141-3820, which is based on the nonfunded region of the Prioritized List. Add reference to the State Plan. Update reference to the OHA Prioritized List. Replace references to a "client" with "Member." Capitalize defined terms.

CHANGES TO RULE:

410-140-0140

Vision Coverage ¶

(1) The Division covers: ¶

(a) Ocular prosthesis (e.g., artificial eye) and related services (OAR 410-122-0640). ¶

(b) Reasonable services for diagnosing conditions, including the initial diagnosis of a condition that ~~is below the funding line~~does not appear on the OHA Prioritized List. When a diagnosis is established ~~for a service, treatment, or item that falls below the funding line~~, the Division may not cover any other State Plan services ~~related to the diagnosis unless the member meets the comorbidity rules (OAR 410-141-3820(10) & (11)) that do not pair with the condition on the OHA Prioritized List~~. ¶

(c) Orthoptic and pleoptic training or "vision therapy" under EPSDT (refer to Division 410, Chapter 151) as followed: ¶

(A) When therapy treatment pairs with a covered diagnosis on the OHA Prioritized List; and ¶

(B) Limited to six (6) sessions per calendar year (no PA required): ¶

(i) The initial evaluation is included in the six (6) therapy sessions; ¶

(ii) Additional therapy sessions require PA (OAR 410-140-0420); ¶

(iii) Providers shall develop a therapy treatment plan and regimen that shall be taught to the ~~m~~Member, family, foster parents, and caregiver during the therapy treatments. No extra treatments shall be authorized for teaching; ¶

(iv) Therapy that can be provided by the ~~m~~Member, family, foster parents, and caregiver is not a reimbursable service; and ¶

(v) All vision therapy services including the initial evaluation shall be billed to the Division with the Current Procedural Terminology (CPT) code for orthoptic and pleoptic training. ¶

(2) Division ~~m~~Members are enrolled for ~~e~~Covered Health Services to be delivered through one of the following means: ¶

(a) ~~Ma~~Coordinated Care Entity (MCE Organization (CCO)) as defined in OAR 410-120-0000. Payment for all vision services provided to ~~MCE m~~CCO Members by ophthalmologists, optometrists, and opticians is a matter between the ~~p~~Provider and the ~~MCE; CCO~~; ¶

(b) Fee-for-~~s~~Service (FFS): ¶

(A) ~~FFS m~~Open Card Members are not enrolled in an ~~MCE CCO~~ and may receive vision services from any Division-enrolled ~~p~~Provider that accepts ~~FFS m~~Open Card Members subject to limitations and restrictions in the visual services program rules; and ¶

(B) All claims must be billed directly to the Division. ¶

(3) When a ~~m~~Member has both Medicare and coverage through the Division, optometrists and ophthalmologists shall bill Medicare first for Medicare covered services. ¶

(4) When a ~~m~~Member has ~~t~~Third-p-Party Liability (TPL) and coverage through the Division, optometrists and ophthalmologists shall bill TPL first for TPL ~~e~~Covered services. ¶

(5) When an ~~OHP m~~Open Card Member receives services on a FFS basis under the Division's rules and has Medicare or TPL coverage: ¶

(a) A ~~p~~Provider may order visual materials from any visual materials supplier; and ¶

(b) The Division does not require PA for Medicare or TPL ~~e~~Covered services. ¶

(6) Coverage for eligible adults (age 21 and older): ¶

(a) One complete examination and determination of refractive state is limited to once every 24 months for non-pregnant ~~m~~Members; ¶

(b) One complete examination and determination of refractive state is limited to once ~~(1)~~ every 24 months for pregnant ~~m~~Members and during the protected post-partum 12-month period (OAR 410-200-0135). ¶

(c) Diagnostic evaluations and medical examinations are not limited if documentation in the ~~p~~Physician's or optometrist's clinical record justifies the medical need for diagnosis; ¶

(d) Ophthalmological intermediate and comprehensive exam services are not limited for allowable medical

diagnosis;¶

(e) Visual services for the purpose of prescribing glasses or contact lenses and fitting fees are as follows:¶

(A) When determined necessary during a limited complete examination and determination of refractive state for pregnant ~~members~~ Members and during the protected post-partum 12-month period (OAR 410-200-0135).¶

(B) Non-pregnant adults are not covered, except when the ~~member~~ Member:¶

(i) Has a medical diagnosis of aphakia, pseudophakia, congenital aphakia, keratoconus; or¶

(ii) Lacks the natural lenses of the eye due to surgical removal (e.g., cataract extraction) or congenital absence; or¶

(iii) Has had a keratoplasty surgical procedure (e.g., corneal transplant) with limitations described in OAR 410-140-0160 (Contact Lens Services and Supplies).¶

(7) OHP Plus Children (birth through age 20):¶

(a) All ophthalmological examinations and vision services, including routine vision exams, fittings, repairs, and materials are covered when documentation in the clinical record justifies the medical need;¶

(b) The standard of care and expectation is that all comprehensive eye exams for children be dilated.¶

(c) With the diagnosis of Amblyopia, band-aid patches treatment shall be covered with a prescription. Quantity limit is ~~sixty (60)~~ per ~~thirty (30)~~ days.¶

(8) Refraction determination is not limited following a diagnosed medical condition (e.g., multiple sclerosis).¶

(9) The Division reimburses all covered surgical procedures as global packages, except when the surgeon codes the surgical procedure with a modifier indicating surgical procedure only, excluding post-operative care.¶

(10) The Division OHP vision benefit packages:¶

(a) For non-pregnant adults (age 21 and older), visual services and materials to diagnose and correct disorders of refraction and accommodation are covered only when the ~~member~~ Member:¶

(A) Has a covered medical diagnosis, following cataract surgery or a corneal lens transplant as described in OAR 410-140-0140; or¶

(B) Is in their protected post-partum 12-month period (see OAR 410-200-0135);¶

(b) For pregnant adult people (age 21 and older) other visual services are covered with limitations as described in these rules;¶

(c) For children (birth through age 20): Visual services are covered as described in this rule and without limitation when documentation in the clinical record justifies the medical need.¶

(11) Post-operative care includes all related follow-up visits and examinations provided within:¶

(a) Ninety (90) days following the date of major surgery; or¶

(b) Ten (10) days following the date of minor surgery; and¶

(c) Claims for evaluation and management services and ophthalmological examinations billed within the follow-up period shall be denied.¶

(12) Provider Error: Neither the contractor nor the Division shall be responsible for costs, expenses or for any required rework due to errors by any ~~provider~~ Provider.

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.025, 414.065, 414.075

RULE SUMMARY: Update reference to the OHA Prioritized List. Replace references to an “managed care entity” or “MCE” with a “coordinated care organization” or “CCO.”

CHANGES TO RULE:

410-140-0410

Provider Responsibility

(1) The Oregon Health Authority (Authority) uses several approaches to promote program integrity and prevent fraud, waste and abuse in the Medicaid program (Refer to OAR 410-120-1395).¶

(2) The Division enrolls the following as providers of vision services:¶

(a) An individual licensed by the relevant state licensing authority to practice optometry; and,¶

(b) A licensed ophthalmologist; and,¶

(c) An optician as defined in ORS 683.510-683.530;¶

(3) The provider must verify whether an ~~MCE~~CCO or the Division is responsible for reimbursement.¶

(a) Providers shall comply with ~~MCE~~CCO policies, including PA requirements, for reimbursement. Providers shall inform ~~MCE~~CCOs of the last date of service when inquiring about service limitations. Failure to follow ~~MCE~~CCO rules may result in the denial of payment; and,¶

(b) If the provider has been denied payment for failure to follow the rules established by the ~~MCE~~CCO, neither the Division, the ~~MCE~~CCO, nor the ~~MCE~~CCO member are responsible for payment; and,¶

(c) If the ~~MCE~~CCO uses the Division's visual materials contractor or another visual materials contractor for visual materials and supplies, all issues shall be resolved between the ~~MCE~~CCO and the contractor; and,¶

(d) Pursuant to OARs 410-120-1560 through 410-120-1700, the Provider may appeal a decision in which the provider is directly adversely affected.¶

(4) Providers shall comply with the following rules in addition to the Visual Services program rules to determine service coverage and limitations for OHP members according to their benefit packages:¶

(a) General Rules (OAR ~~C~~chapter 410, ~~D~~division 120);¶

(b) OHP administrative rules (~~C~~chapter 410, ~~D~~division 141);¶

(c) ~~Health Evidence Review Commission's (HERC)~~OHA Prioritized List of Health Services (OHA Prioritized List) (OAR 410-141-3830); and,¶

(d) Referenced guideline notes (The date of service determines the correct version of the administrative rules and ~~HERC~~OHA Prioritized List to determine coverage.); and,¶

(e) The Authority's general rules related to provider enrollment and claiming (OAR 943-120-0300 through 1505).¶

(5) Providers must verify that an individual is an OHP member and eligible for benefits prior to providing services to ensure reimbursement for services provided. If the provider fails to confirm eligibility on the date of service, the provider may not be reimbursed. Providers must verify the member's eligibility including:¶

(a) That the individual receiving vision services is eligible on the date of service for the service provided;¶

(b) Whether an OHP member receives services on a FFS basis or is enrolled with an ~~MCE~~CCO;¶

(c) That the service is covered under the member's OHP Benefit Package; and,¶

(d) Whether the service is covered by a third party resource (TPR).¶

(6) Providers must maintain accurate and complete member records, which includes documenting the quantity of services provided, as outlined in OAR 410-120-1360 (Requirements for Financial, Clinical and Other Records). For comprehensive eye exams, the standard of care and expectation is that the provider shall provide a dilated exam and document the type of dilating drops and time of dilation.¶

(7) Providers must keep a copy of the delivery invoice included with all parts orders in the member's records or document the delivery invoice number in the member's records for all repair and refitting claims.¶

(8) The provider shall inform an OHP member when:¶

(a) Vision service or materials are not covered under the members benefit package;¶

(b) Service limitations have been met and the benefit is no longer covered.¶

(9) Providers must:¶

(a) Verify the member's eligibility and benefit coverage prior to submitting vision material orders to the contractor;¶

(b) Obtain PA from the Division for items requiring PA prior to placing a vision materials order;¶

(c) Comply with the contractor's order submission requirements, as outlined in the Visual Services Supplemental Information Guide found at Division website: <http://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Vision.aspx>;¶

(d) Submit prescription or order to the contractor upon notification of PA approval from the contractor; and,¶

(e) Pay SWEEP Optical for any services, materials, and supplies provided by SWEEP Optical to a member who is not eligible for items. SWEEP Optical may not sell materials and supplies for non-eligible members at the State Contracted Price.¶

(10) Post-operative care provided outside the global package is:¶

(a) Reimbursable to optometrists when furnished within their scope of practice;¶

(b) Billed with:¶

(A) The surgical CPT code billed by the surgeon;¶

(B) The appropriate modifier noting post-operative care only; and,¶

(C) The first post-operative date of service; and,¶

(c) Reimbursed a percentage of the global reimbursement.¶

(11) Providers are responsible for:¶

(a) Verifying member eligibility prior to submitting an order to the contractor. Refer to OAR 410-120-1140

Verification of Eligibility;¶

(b) Obtaining prior authorization (PA) from the Division for items requiring PA prior to placing a vision materials order. (See OAR 410-140-0040 Prior Authorization.);¶

(c) Complying with the contractor's order submission requirements, as outlined in the Visual Services Supplemental Information Guide found on this Division website:

<http://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Vision.aspx>;¶

(d) Submitting prescription/order to the contractor upon notification of PA approval from the contractor; and,¶

(e) Paying SWEEP Optical for any services provided by SWEEP Optical to a member who is not eligible for items. SWEEP Optical is prohibited by contract to sell materials and supplies for non-eligible members at the State Contracted Price.¶

(12) Provider Error: Neither the contractor nor the Division shall be responsible for costs, expenses or for any required rework due to errors by any provider.¶

(13) It is the provider's responsibility to contact the member's PHP of CCO and give them the last date of service. The current PHP or CCO shall then determine if they want to allow for an additional supply of glasses. If the member is an established member, regardless of incomplete information through phone or electronic verification systems or SWEEP Optical, it is the provider's responsibility to inform the PHP/CCO of the last date of service.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: 414.025, 414.065, 414.591, 414.631

RULE SUMMARY: Remove reference to a funding line on the Prioritized List, and to funded/unfunded regions. Update reference to the OHA Prioritized List. Replace comorbidity guidance with requirements for conducting an individual medical necessity review. Replace references to funded/unfunded services with covered/noncovered services. Revise the ad hoc review process for services that do not pair on the Prioritized List. Update OAR references (e.g., to OAR 410-141-3855). Replace references to a "member" with "CCO Member" where appropriate. Replace references to an "managed care entity" or "MCE" with a "coordinated care organization" or "CCO." Capitalize defined terms.

CHANGES TO RULE:

410-141-3820

Covered Services

(1) General standard. ~~The health services that comprise the OHP Bbenefit Ppackage includes treatments and health services which pair together with a condition on the same line of~~ are identified in the State Medicaid Plan (State Plan) and also identified in and consistent with the health services listed in the Health Evidence Review Commission (HERC) Prioritized List of Health Services adopted under OAR 410-141-3830, to the extent that such line appears in the funded portion of the Prioritized List of Health Services. Coverage of these services is included in the benefit package when provided as specified. These services are covered when provided as specified by the Condition/Treatment Pairs and any relevant statements of intent and guideline notes as detailed in the OHA Prioritized List of Health Services (OHA Prioritized List), which is also consistent with, as recommended to OHA by HERC, with the HERC Prioritized List of Health Services. The OHA Prioritized List of Health Services (OHA PLHS) in any relevant Statements of Intent and Guideline Notes adopted by reference in OAR 410-141-3830 and in effect of the Prioritized List of Health Services date services are provided. The ~~Bbenefit Ppackage~~ also covers the additional services described in this rule. / ¶

(a) ~~As used~~ "Health Services" has the meaning given in ORS 410-141-3820 and OAR 410-141-3825, the word "h4.025 and includes all of the services in the State Plan, which are also identified in the OHA Prioritized List, services approved by CMS in the 1115 Waiver, and health services that are otherwise identified as included in OAR Chapter 410. "Health sServices" has the meaning given in ORS 414.025(13); are also referred to in this rule and other rules in OAR Chapter 410 as "Oregon Health Plan Services" or "OHP Services." ¶

(b) ~~OHP Services are covered with respect to an individual mMember only when the services are mMedically nNecessary and mMedically or dDentally aAppropriate as defined in OAR 410-120-0000 and at the time they are provided, except that services shall also meet the prudent layperson standard defined in ORS 743A.012;~~ ¶

(c) Emergency Services (defined in OAR 410-120-0000) are covered only when those Members, including EPSDT Beneficiaries, are experiencing an Emergency Medical Condition, meaning they are experiencing symptoms that are so severe that a prudent layperson could believe they need immediate medical attention to avoid serious harm as defined in OAR 410-120-0000. / ¶

(~~d~~) ~~HRSN~~ Health Related Social Needs (HRSN) services are covered with respect to an individual mMember only when the Member belongs to an HRSN Ccovered Ppopulation and meets other service-specific eligibility criteria as defined in OARs 410-120-0000, OAR 410-120-2000, and OAR 410-120-2005; / ¶

(~~e~~) ~~Benefit Ppackage coverage of prescription drugs is discussed in OAR 410-141-3855;~~ / ¶

(~~f~~) ~~The Bbenefit Ppackage is subject to the exclusions and limitations described in OAR 410-141-3825.~~ / ¶

(2) ~~MCEs~~ OHP Service oOfferings; / ¶

(a) ~~MCEs shall offer their m~~ The Authority and CCOs shall provide their respective Members with, at a minimum: / ¶

(A) ~~The physical, behavioral and/or oral hHealth sServices covered under the mCCO Member's benefit package, as appropriate for the MCE's mandatory scope of services; and~~ / ¶

(B) ~~A~~ With respect to Open Card Members only, any additional services required in OAR chapter 410; or ¶

(C) With respect to CCO Members only, any additional services identified in OAR chapter 410 or in the MCECCO contract. / ¶

(b) ~~CCOs shall~~ Service coordinateion of physical health, behavioral health, oral health care benefits, and HRSN benefits; / ¶

(c) ~~With respect to mMembers who are dually eligible for Medicare and Medicaid, MCECCOs shall provide;~~ / ¶

(A) ~~OHP Bbenefit Ppackage services except for Medicaid-funded long-term care, services, and supports; and~~ / ¶

(B) ~~Secondary payment for services covered by Medicare but not otherwise covered under the Oregon Health Plan as specified in OAR 410-141-3565 and specific to benefit packages in OAR 410-120-1210.~~ / ¶

(3) Diagnostic services. Diagnostic services that are ~~mMedically or dDentally aAppropriate and mMedically nNecessary to diagnose the mMember's presenting condition (signs and symptoms) or guide management of a mMember's condition, regardless of whether the condition appears above or below the funded line on the~~ in the

State Plan, the OHA Prioritized List, of Health Services, the diagnostic workup file provided by the Authority at [web]. Coverage of diagnostic services is subject to any applicable Diagnostic Guidelines in the OHA Prioritized List of Health Services. ¶

(4) Comfort care. Comfort care is a covered service for a member. ¶

(4) Palliative Care must be covered for CCO Members with a terminal illness who have a life-threatening or serious progressive illness as described in OAR 410-141-3846. ¶

(5) Preventive services. Preventive services are included in the OHP benefit package as described in the funded portion of the Prioritized List of Health Services, OHA Prioritized List and as specified in related guideline notes. These services include, but are not limited to: periodic medical and dental exams based on age, sex, and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors. ¶

(6) Ancillary services. Ancillary services are covered according to their inclusion on the ancillary file provided by the Authority at [web] and subject to the service limitations of the Oregon Health Plan (OHP) program rules when: ¶

(a) The services are Medically Necessary and Medically or Dentally Appropriate in order to provide a funded covered service; or ¶

(b) The provision of ancillary services shall enable the member to retain or attain the capability for independence or self-care. ¶

(c) Coverage of ancillary services is subject to any applicable Ancillary Guidelines in the OHA Prioritized List of Health Services. ¶

(7) Telehealth Services. Telehealth services must be provided in compliance with OAR 410-120-1990. ¶

(8) SUD and any applicable program rules for the service. ¶

(8) Substance Use Disorder (SUD) services. The provision of SUD services shall must comply with OAR 410-141-3545. ¶

(9) Services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart k. ¶

(10) Services necessary for compliance with the requirements for Early and Periodic Screening, Diagnosis and Treatment as specified in the Oregon Health Plan 1115 Demonstration Project (waiver) and meeting requirements for individualized determination of medical necessity as specified in meeting requirements for individualized determination of Medically Necessary and Medical and Dentally Appropriate as described in OAR chapter 410, division 151. Where a provision in this rule refers to Medically Necessary and Medically Appropriate or Dentally Appropriate, the provision shall be read to include EPSDT Medically Necessary and EPSDT Medically Appropriate or EPSDT Dentally Appropriate when making service authorization determinations for an EPSDT Beneficiary as defined in OAR 410-151-0002. ¶

(11) Services necessary for compliance with the requirements for HRSN services (as described in Oregon's Medicaid 1115 Waiver for 2022-2027) and meeting requirements for individualized determination of service authorization as specified in OAR 410-141-3835-20-2020. ¶

(12) Services necessary for compliance with the requirements for Reentry FCAA Federal Consolidated Appropriations Act (FCAA) Services for CCO Members who are FCAA-Covered Youth. Eligibility criteria and service requirements for Reentry FCAA Services are described in OARs 410-155-0000 and OAR 410-155-0010. ¶

(13) Coverage of services for unfunded conditions based on effect on funded comorbid conditions: ¶

(a) The OHP Benefit Package includes coverage in and subject to individual clinical factors, including the presence of Comorbidities: Policy statement and review criteria requirements. ¶

(a) Services when paired with condition to that available under subsection (1). Specifically, it includes coverage of certain ms on the OHA Prioritized List of Health Services (OHA Prioritized List) are presumptively Medically Necessary and appropriate services for conditions which appear below the funding Medically Appropriate as set forth in 410-141-3830. ¶

(b) Service requests that do not: pair with conditions on the OHA Prioritized List; meet the applicable relevant statements of intent or practice guideline is on the OHA Prioritized List; of Health Services if r meet other medical necessity can be shown that: ¶

(A) The member has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and ¶

(B) The criteria utilized by the CCO, are presumptively not Medically Necessary and Medically Appropriate. However, a service that is presumptively not Medically Necessary and Medically Appropriate must be covered to treat a Member's concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition if it is determined to be Medically Necessary and Appropriate for that individual Member subject to subsection (c) of this section (13), when the service is subject to Prior Authorization, and subsection; and ¶

(C) Treating the unfunded medically related condition may significantly improve the outcome of treating the

funded condition. ¶¶

~~(b) Services that are expressly excluded from coverage as described in OAR 410-141-3825 are not subject to~~
~~cons(d) of this section (13), when a Claim for services provided is appealed. In such circumstances, a reviewer shall~~
~~use their clinical expertise and judgment to determine Medical Necessity and Medical Appropriateness by~~
~~considering the clinical documentation (which may include any available clinical literature) and a Letter of Medical~~
~~Necessity submitted by the Provideration for coverage under subsection (14); that includes: ¶¶~~

~~(eA) Any co-Comorbid eConditions or disability shall be represented by an ICD diagnosis code or, when the~~
~~condition is a mental disorder, represented by a DSM diagnosis(as defined in 410-120-0000) and how they impact~~
~~or are impacted by the condition for which the service has been requested; ¶¶~~

~~(dB) In order forHow or why the services to be covered, there shall be a medical determination and finding by the~~
~~Authority (for fee for service OHP clients) or by the MCE (for MCE members) that the terms of subsection (a) of~~
~~this rule have been met based upon the applicable: ¶¶~~

~~(A) Treating health care provider opinion; ¶¶~~

~~(B) Medical research; and paired with the Member's condition on the OHA Prioritized List are ineffective or are~~
~~contraindicated or not applicable; and ¶¶~~

~~(C) How the requested service may be reasonably expected to significantly improve the clinical outcomes for the~~
~~Member in the presence of the Comorbid Conditions or other clinical factors. ¶¶~~

~~(Cc) Current peer review. ¶¶~~

~~(14) Ensuring that all coverage options are considered: ¶¶~~

~~(a) When a provider receives a denial for a non-covered service for any member, especiallyFor services subject to~~
~~Prior Authorization, an individualized review of the Member's records must be conducted in accordance with 42~~
~~CFR § 438.210(b)(3) prior to issuing a denial. All such reviews must be documented in a membanner with a~~
~~disability or with a co-morbid condition, the provider shall determine whether there may be a mthat demonstrates~~
~~compliance with OAR 410-141-3835(13)(e) and this rule, including, without limitation, that the determination of~~
~~Medical Necessity and Medically a Appropriate covered service to address the member's condition or clinical~~
~~situation, before declining to provide the non-covered service. The provider's determination shall include~~
~~consideration of whether a service for an unfunded condition may improve a funded comorbid condition under~~
~~subness was: ¶¶~~

~~(A) Made by a Practitioner who met the applicable requirements identified in 410-141-3835: ¶¶~~

~~(B) Made in consideration of the opinion of the Member's treating Provider(s), such as in a Letter of Medical~~
~~Necessity: ¶¶~~

~~(C) Based on current, peer reviewed, medical or health literature; and ¶¶~~

~~(D) As applicable, other professionally recognized, accepted, reliable resources, and standards. ¶¶~~

~~(d) If a Claim for services provided is appealed, the Claim must be reviewed in accordance with (b) and (c) of this~~
~~section (14);3). ¶¶~~

~~(be) If a member seeks,Any Comorbid conditions or d is recommended, a non-covered service, providers shall~~
~~ensure that the member is informed of:abilities for consideration under this section shall be represented by a~~
~~diagnosis code. ¶¶~~

~~(Af) Clinically appropriate treatment that may exist, whether covered or not; ¶¶~~

~~(B) Community resources that may be willing to provide the relevant non-covered service;Services, including~~
~~prescription drugs, that are expressly excluded from coverage as described in OARs 410-120-1200, 410-141-~~
~~3825, 410-141-3855, and program-specific rules within chapter 410 are not subject to individualized~~
~~consideration for coverage under this section (13). ¶¶~~

~~(Cg) If appropriate, future health indicators that may warrant a repeat evaluation visit. ¶¶~~

~~(c) Before an MCE denies coverage for an unfunded service for any member, especially a member wServices for~~
~~EPSDT Beneficiaries are subject to separate individualized coverage considerations as described in OAR 410-141-~~
~~3820(10). ¶¶~~

~~(14) When determining Medical Necessity a disability or with a co-morbid condition, the MCE shall determine~~
~~whether the member has a funded condition or condition/treatment pair that may entitle the member to coverage~~
~~under the program.nd Medical Appropriateness and Dentally Appropriateness as defined in OAR 410-120-0000~~
~~for an OHP Service that is subject to Prior Authorization, CCOs and all CCO Subcontractors must comply with~~
~~OAR 410-141-3835 (CCO Service Authorization). ¶¶~~

~~(15) Assistance to pProviders. The Authority shall maintain a telephone information line for the purpose of~~
~~assisting pPractitioners in determining coverage under the OHP Bbenefit Ppackage. The telephone information~~
~~line shall be staffed by registered nurses who shall be available during regular business hours. If an emergency need~~
~~arises outside of regular business hours, the Authority shall make a retrospective determination under this section,~~
~~provided the Authority is notified of the emergency situation during the next business day. If the Authority denies a~~
~~requested service, the Authority shall provide written notification and a notice of the right to an administrative~~
~~hearing to both the OHP mMember and the treating pPhysician within five (5) working days of making the~~

decision. / ¶

(16) Ad hoc coverage determinations. / ¶

(a) When a ~~member~~ OHP Member requests a ~~Contested Case Hearing~~ pertaining to a ~~funded condition and a funded or unfunded treatment~~ treatment and condition that does not pair on the ~~HERC~~ OHA Prioritized List of Health Services, and the treatment is not included in the excluded services guideline ~~no~~, the Authority shall, prior to the dates of the prioritized list, ~~before the Contested Case Hearing~~ the Division shall, review the Member's service request to determine ~~if whether~~ whether the requested treatment is appropriate and necessary for the member. ¶

~~(b) For treatments determined to be appropriate and necessary under subsection (a), the Division~~ service is Medically Necessary and Medically Appropriate and make such determination in accordance with Section (b) below of this section (16). ¶

~~(b) If the Authority determines whether the that~~ that HERC has ~~not~~ considered the ~~funded c~~ Condition/t Treatment ~~p~~ Pair for inclusion on the HERC Prioritized List of Health Services within the last five (5) years. ~~If the HERC has not considered the pair for inclusion within the last five (5) years, the Division and as a result the Authority did not have the opportunity to consider including the Condition/Treatment Pair in the OHA Prioritized List, the Authority shall make an ad hoc coverage determination in consultation with the HERC of whether the requested service is Medically Necessary and Medically Appropriate as defined in OAR 410-120-0000. ¶~~

~~(c) For treatments determined to not be a~~ lf the Authority determines the requested services are not Medically Necessary and Medically Appropriate ~~and necessary under~~ er subsection (a) in this section ~~the hearing process~~ (16), the Contested Case Hearing shall proceed. / ¶

(17) General anesthesia for dental procedures. General anesthesia for dental procedures that are ~~not~~ Medically Necessary and Medically or ~~d~~ Dentally a Appropriate to be performed in a hospital or ambulatory surgical setting may be used only for those ~~member~~ Members as detailed in OAR 410-123-1490.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065, 414.572, 414.605, 414.665, 414.719

RULE SUMMARY: Remove reference to a funding line on the Prioritized List. Remove reference to uncovered diagnoses, as all diagnoses on Prioritized List will now be covered. Replace reference to funded services with covered services. Eliminate duplicative language and revise for clarity and readability. Update section reference. Replace references to a "client" with "Member" and "member" with "CCO Member." Replace references to an "managed care entity" or "MCE" with a "coordinated care organization" or "CCO." Capitalize defined terms.

CHANGES TO RULE:

410-141-3825

Excluded Services and Limitations

(1) The following services are excluded from the Oregon Health Plan ~~Benefit Package~~, except as otherwise provided in OAR 410-141-3820: ¶

(a) ~~Any~~ services identified for exclusion in OARs 410-120-1200 or 410-120-1210; ¶

(b) ~~Any~~ services identified in applicable ~~p~~Provider guides as a non-covered service, unless the service is identified as specifically covered under the OHP administrative rules; ¶

(c) ~~Any~~ service ~~that is not a funded service, even if it is provided for a condition that appears in the funded region of the list, or if the service in question is a funded service when provided for an unfunded diagnosis on the prioritized list;~~ ¶

(d) ~~Services that, when provided, are funded services~~ identified by the Authority using applicable codes in the excluded services file maintained by the Authority, in consultation with HERC, on its website at: [web TBD]; ¶

(d) ~~Services that appear on the OHA Prioritized List of Health Services (OHA Prioritized List), but which are otherwise excluded from the specific OHP Bbenefit Ppackage for the clientMembers in question;~~ ¶

(e) Diagnostic services not reasonably necessary to establish a diagnosis or guide management or treatment decisions, regardless of whether the ~~condition or treatment in question is a funded service~~ service in question appears on the OHA Prioritized List per OAR 410-141-3830; ¶

(f) Services requested by ~~OHP clientMembers~~ in an emergency care setting that do not satisfy the coverage rules in OAR 410-141-3820; ¶

(g) Services provided to an ~~OHP client Member~~ outside the territorial limits of the United States, except in those instances in which the country operates a Medical Assistance (Title XIX) program; ¶

(h) Services other than inpatient care provided to an OHP client who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, per OAR 410-141-3810; ¶

(i) Services received while ~~the client~~ a CCO Member is outside the ~~MCECCO's~~ service area, except for services that were: ¶

(A) Ordered or referred by the ~~client~~ CCO Member's ~~pPrimary eCare pProvider~~; or, ¶

(B) Urgent Care Services or ~~eEmergency sServices~~ as defined in OAR 410-120-0000; or, ¶

(C) Otherwise covered pursuant to an administrative rule or the ~~MCECCO~~ contract; ¶

(D) ~~These exclusions listed in this subsection (1)(i) does not apply if the clientCCO Member was outside the MCECCO's service area because of circumstances beyond the clientCCO Member's control. Factors to be considered include, but are not limited to, the death of a family member outside of the MCECCO's service area. If the clientCCO Member successfully establishes this fact, including at they were out of the CCO's service area due to circumstances beyond their control, regardless of whether such establishment is made during the grievance and aAppeal process, then this exclusion does not apply.~~ service(s) must be covered by the CCO if the service(s) would have been covered had the service(s) been provided in the CCO's service area. ¶

(2) The following ~~sOHP Services~~ are limited or restricted: ¶

(a) Any service which exceeds those that are ~~mMedically aAppropriate and nMedically Necessary to p;~~ ¶

(A) Provide reasonable diagnosis and treatment; enable the OHP client to attain or retain the capability for independence or self-care; or screen for preventable disease or disease exacerbation. This limitation includes, including services that, upon medical review, could not reasonably have been expected to provide more than minimal benefit in treatment or information to aid in a diagnosis; ¶

(b) ~~Diagnostic services not reasonably required to diagnose a presenting problem, whe~~ Enable the Member to attain or retain their the resulting diagnosis and indicated treatment ability for independence or self-care; on the currently funded lines under the OHP Prioritized List of Health Services; ¶

(C) Screen for preventable disease or disease exacerbation; ¶

(e) ~~b~~ Services that are limited under OARs 410-120-1200 and 410-120-1210.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Expand the description of the Prioritized List of Health Services and describe how it will be used to define covered services for the Oregon Health Plan. Describe and adopt the OHA Prioritized List of Health Services, consistent with the HERC Prioritized List of Health Services.

CHANGES TO RULE:

410-141-3830

Prioritized List of Health Services

- (1) The ~~Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List) is the listing of physical and behavioral h~~Oregon Health Authority (Authority or OHA) has developed: ¶
- (a) A State Medicaid Plan benefit package (OHP Services) that is, in compliance with ORS 414.065, consistent with the services and treatments identified in the Health Evidence Review Commission (HERC) Prioritized List of Health Services; and ¶
- (b) An OHA Prioritized List of Health Services as defined in OAR 410-120-0000; and. ¶
- (c) The OHA Prioritized List of Health Services is based on recommendations from HERC with the intent and goal that the OHA Prioritized List of Health sServices generated and maintained by HERC. The Authority may apply criteria listed in Statements of Intent and Practice Guidelines (Gbe substantively similar to and consistent with the HERC Prioritized List of Health Services. Accordingly, where the OHA Prioritized List of Health Services includes those services identified in the HERC Prioritized List of Health Services, the lists are substantively similar with respect to the diagnosis and treatment codes, guideline Nnotes, Aancillary Gguideline Nnotes, Ddiagnostic Gguideline Nnotes and E_excluded Sservices Gguideline Nnotes) from the Prioritized List to codes and lines not explicitly specifi, statements of intent, coding specifications and annotations. ¶
- (2) For the purposes described below in this rule, effective as of January 1, 2027, the Authority adopts the entirety of the OHA Prioritized List in full as described in subsection (1)(b) above as it is in effect on the same date. ¶
- (a) The OHA Prioritized List as adopted by the Authority is incorporated into that guideline note and to services such as diagnostic, ancillary and excluded irrespective of their inclusion on the lines of the Prioritized List. The HERC maintains the most current list on their website: <https://www.oregon.gov/OHA/HPA/DSI-HERC/Pages/is> rule by this reference. ¶
- (b) The Authority must: ¶
- (A) Cease its use of the OHA Prioritized List of Health Services described in subsections (1)(b)-(c) as its practice guidelines for OHP Services effective no later than 11:59pm on December 31, 2027 and timely engage in the rule making process that is necessary to effectuate such cessation: ¶
- (B) Adopt by rule the HERC Prioritized List of Health Services that HERC approved for the 2027-29 biennium as the Authority's practice guidelines for OHP Services effective no later than Midnight on January 1, 2028 and timely engage in the rule making process that is necessary to effectuate such adoption and use. ¶
- (C) In all cases, adopt the rules described in subsections (A)-(B) of this section (c) with effective dates that require the Authority to cease its use of the OHA Prioritized List.aspx. For a hard copy, contact the Division within the Oregon Health Authority (Authority). ¶
- (2) This of Health Services as of the date and time that the Authority adopts and commences using the HERC Prioritized List of Health Services that HERC approved for the 2027-29 biennium. ¶
- (3) The conditions and treatments paired on the OHA Prioritized List, along with any criteria listed in rule, effevant statements of intent and practice February 1, 2026, incorporates by reference the February 1, 2026 Prioritized List, funded through line 470 and including all line items, diagnosis and treatment codes, guideline notes, statements of intent, coding specifications and annotations. This Prioritized List dated February 1, 2026 supersedes the January 1, 2026 Prioritized List for services provided after February 1, 2026, and includes interim modifications reported as required under ORS 414.690(7) and (8)guidelines (guideline notes, ancillary guideline notes, diagnostic guideline notes and excluded services guideline notes), are presumptively Medically Necessary and Medically Appropriate for the OHP population and are included as OHP Services (as defined in OAR 410-141-3820). ¶
- (a) The OHA Prioritized List serves as the Authority's practice guidelines for OHP Services as defined by 42 CFR §438.236. The OHA Prioritized List, which is based on and consistent with the HERC Prioritized List, meets the criteria for the practice guidelines required under 42 CFR §438.236 (b) in the following manner: ¶
- (A) It is based on valid and reliable clinical evidence or a consensus of Providers in the particular field; ¶
- (B) It considers the needs of the Members; ¶
- (C) It is adopted in consultation with contracting health care professionals; and ¶
- (D) It is reviewed by OHA and, if necessary, updated from time to time as recommended by HERC; and ¶
- (E) It is distributed publicly as updated. ¶

(b) OHP Services are provided to Members when they are Medically Necessary and Medically Appropriate as described in OAR 410-141-3820, 410-141-3835, and, as applicable, OAR chapter 410, division 151. An OHP Service for a Member may be limited or denied based on a determination that the OHP Service is not Medically Necessary or not Medically Appropriate for that Member per OAR 410-141-3820, 410-141-3835, and, as applicable, OAR chapter 410, division 151. ¶

(c) If a CCO Member's condition does not pair on the OHA Prioritized List with the OHP Service requested, then the OHP Service is considered presumptively not Medically Necessary and Medically Appropriate. However, CCOs must conduct an individual medical necessity review including the consideration of applicable Comorbid Conditions for certain Prior Authorization requests for non-EPSDT Beneficiaries, as described in 410-141-3820(13). ¶

(d) In determining whether Diagnostic or Ancillary Services are Medically Necessary and Medically Appropriate, the Authority and its contracted CCOs must make those determinations as outlined in OARs 410-120-1160, 410-120-1200, 410-130-0220, 410-141-3820, 410-141-3825, 410-141-3835 and chapter 410, division 151, using the applicable code files identified by the Authority. The Authority maintains the current diagnostic and ancillary code files, in consultation with HERC, on its website at: [web]. For a hard copy, contact the Division within the Authority. ¶

(e) The criteria included in the statements of intent and guideline notes included with the OHA Prioritized List may be applied to codes and lines not explicitly specified in that statement of intent or guideline note, and to services such as diagnostic, ancillary and excluded services, irrespective of their inclusion on the lines of the OHA Prioritized List.

Statutory/Other Authority: ORS 414.065, 413.042

Statutes/Other Implemented: ORS 414.065, 414.727

RULE SUMMARY: Describe documentation requirements when an individual medical necessity review is completed. Replace references to a "member" with "CCO Member." Replace references to an "managed care entity" or "MCE" with a "coordinated care organization" or "CCO." Capitalize defined terms.

CHANGES TO RULE:

410-141-3835

CCO Service Authorization

(1) Coverage of ~~s~~OHP Services is outlined by CCO contract and Oregon Health Plan (OHP) benefits coverage in OARs 410-120-1210 and ~~OAR, 410-120-1160, and 410-141-3820.~~¶

(2) A ~~m~~CCO Member may access ~~u~~Urgent Care and ~~e~~Emergency ~~s~~Services, as defined in OAR 410-120-0000, 24 hours a day, seven (7) days a week without prior authorization.¶

(3) ~~The CCOs~~ must not require a ~~m~~CCO Member to obtain the approval of a ~~p~~Primary ~~e~~Care ~~p~~Physician to gain access to behavioral assessment and evaluation services. A ~~m~~CCO Member may self-refer to assessment, evaluation, and behavioral health services from the Provider Network. CCO Members may obtain primary care services in a behavioral health setting, and behavioral health services in a primary care setting without a ~~p~~Prior ~~A~~uthorization.¶

(4) A ~~m~~CCO Member may access the following outpatient services from within the CCO's Provider Network, without Prior Authorization, including but not limited to:¶

(a) "Assertive Community Treatment" as defined in OAR 309-019-0105, "Enhanced Care Services" as defined in OAR 309-019-0105, "Enhanced Care Outreach Services" as defined in OAR 309-019-0105, "Wraparound" as defined in OAR 309-019-0105, "Behavior Supports, Crisis Care" as defined in OAR 309-019-0105, "Respite Care" as defined in OAR 309-019-0105, and "Intensive Outpatient Services and Supports" as defined in OAR 309-019-0105;¶

(b) Behavioral Health Peer Delivered Services as defined in OAR 309-019-0125 from within the CCO's Provider Network;¶

(c) Medication-Assisted Treatment for Substance Use Disorders as defined in OAR 309-019-0105, including opioid and opiate use disorders. Prior a ~~A~~uthorization may only be required:¶

(A) For a medication approved by the United States Food and Drug Administration after January 1, 2024; or,¶

(B) For a brand name drug for medication-assisted treatment if a generic equivalent is available to substitute for the prescribed brand name drug. For the purposes of this rule, a different formulation of the medication is not a generic equivalent.¶

(d) Drugs prescribed for the prevention or treatment of human immunodeficiency virus (HIV):¶

(A) When the drug has been approved by the United States Food and Drug Administration for the prevention or treatment of HIV and determined to be ~~m~~Medically ~~n~~Necessary by the prescribing ~~p~~Provider;¶

(B) Step therapy must also not be required for these drugs.¶

(5) ~~Contractor~~CCOs must permit out-of-network IHCPs to refer a CCO-enrolled American Indian/Alaska Native to a ~~n~~Network ~~p~~Provider for ~~e~~Covered ~~s~~Services as required by 42 CFR 438.14(b)(6).¶

(6) The CCO shall ensure the services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to ~~beneficiaries under FFS Medicaid and Open Card Members~~ as described in ORS chapter 414 and applicable administrative rules, ~~based on~~consistent with the OHA Prioritized List of Health Services and OARs 410-120-1160, 410-120-1210, and 410-141-3830.¶

(7) CCOs must not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the ~~beneficiary~~CCO Member.¶

(8) CCOs shall observe required timelines for standard authorizations, expedited authorizations, and specific OHP rule requirements for authorizations for services, including but not limited to residential treatment or substance use disorder treatment services and requirements for advance notice set forth in OAR 410-141-3885. CCOs shall observe required ~~standards for~~timely access to service ~~timelines~~ as indicated in OAR 410-141-3515.¶

(9) CCOs may place appropriate limits on a service authorization for Covered Services based on Medical Necessity and Medical Appropriateness as defined in OAR 410-120-0000, or for utilization control provided that the CCO:¶

(a) Ensures the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished;¶

(b) Authorizes the services supporting individuals with ongoing or chronic conditions or those conditions requiring long-term services and supports in a manner that reflects the ~~m~~CCO Member's ongoing need for the services and supports;¶

(c) Provides family planning services in a manner that protects and enables the ~~m~~CCO Member's freedom to choose the method of family planning to be used consistent with 42 CFR § 441.20 and the member's free choice of

~~p~~Provider consistent with 42 USC § 1396a(a)(23)(B) and 42 CFR § 431.51; and,¶

(d) Ensures compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, delay, or discontinue ~~m~~Medically ~~n~~Necessary services to any ~~m~~CCO Member.¶

(10) CCOs must not use quality of life in general measures in establishing utilization controls (e.g., ~~p~~Prior ~~a~~Authorization) or otherwise making benefit determinations per OAR 410-120-1320.¶

(11) Once a ~~m~~CCO Member is determined to be eligible for ~~h~~Health-~~r~~Related ~~s~~Social ~~n~~Needs (HRSN) Services as outlined in OARs 410-120-2000, ~~OAR through~~ 410-120-2005, and ~~OAR 410-120-2012~~ 410-120-2012~~25~~, CCOs may place appropriate limits on a service authorization for HRSN Services or for utilization control provided the CCO:¶

(a) Ensures the HRSN Services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished;¶

(b) Authorizes the HRSN Services supporting individuals with ongoing or chronic conditions or those conditions requiring long-term services and supports in a manner that reflects the ~~m~~CCO Member's ongoing need for the services and supports; and,¶

(c) Ensures compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, delay, or discontinue the delivery of HRSN Services to any ~~m~~CCO Member who is eligible for those services under OARs 410-120-2000, ~~OAR through~~ 410-120-2005, and ~~OAR 410-120-2012~~ 410-120-2012~~25~~.¶

(12) For authorization of services:¶

(a) Each CCO shall follow the following timeframes for ~~a~~Prior Authorization requests other than for drug or HRSN services:¶

(A) For standard authorization requests for services not previously authorized and not for repairs of complex rehabilitation technology as defined in Section 2 of Enrolled SB 549 (2025), provide notice per paragraph (G) in this section as expeditiously as the ~~m~~CCO Member's condition requires and no later than seven (7) calendar days following receipt of the request for service.¶

(B) For expedited authorization decisions, provide notice per paragraph (G) in this section as expeditiously as the ~~m~~CCO Member's health condition requires and no later than 72 hours after receipt of the request for service, which period of time shall be determined by the time and date stamp on the receipt of the request;¶

(C) If additional documentation is required to render a decision for requests in paragraphs (A) and (B), make one (1) attempt to obtain the information during the seven (7) calendar day standard review period or 72 hour expedited review period.¶

(D) An extension of up to fourteen (14) calendar days for a standard or expedited authorization decision in paragraph (A) or (B) is ~~p~~ermissible if the following applies:¶

(i) The ~~m~~CCO Member, the ~~m~~CCO Member's ~~r~~Representative, or ~~p~~Provider requests an extension; or,¶

(ii) The CCO needs additional information to process the request, and the extension is in the ~~m~~CCO Member's interest. If the Authority requests, the CCO ~~will~~must justify a need for the additional information and explain how the extension is in the ~~m~~CCO Member's interest.¶

(E) If a fourteen (14) calendar day extension has been justified, the CCO shall:¶

(i) Give written notice to the ~~m~~CCO Member of the reason for the extension;¶

(iii) Respond to the request for authorization per paragraph (G) in this section as expeditiously as the ~~m~~CCO Member's health or mental health condition requires, but no later than the expiration of the extension; and,¶

(iii) If the reason for the extension is to obtain additional documentation, make two (2) attempts to obtain the information during the extended review period in addition to the attempt required in paragraph (C) for the initial review period. ~~The total of three (3) attempts shall include the use of two (2) methods~~different methods of contact or communication to obtain the information.¶

(F) For all ~~p~~Prior ~~a~~Authorization requests for repairs of complex rehabilitation technology as defined in Section 2 of Enrolled SB 549 (2025), provide notice per paragraph (G) in this section as expeditiously as the ~~m~~CCO Member's condition requires and no later than 72 hours following receipt of the request for service. No extension shall be allowed.¶

(G) Responses to requests for ~~p~~Prior ~~a~~Authorization of services in paragraphs (A), (B), (E) and (F) in this subsection ~~(12)(a)~~ shall be in one of the following forms:¶

(i) A written, electronic, or telephonic notice of the approval of the service as requested to the requesting ~~p~~Provider; or,¶

(ii) A written notice of ~~a~~Adverse ~~b~~Benefit ~~d~~Determination per OAR 410-141-3885 to the requesting ~~p~~Provider, the ~~m~~CCO Member and the ~~m~~CCO Member's ~~r~~Representative.¶

(b) Prior ~~a~~Authorization requests for outpatient drugs, including a practitioner administered drug (PAD), shall be addressed by the CCOs as follows:¶

(A) Respond to requests for ~~p~~Prior ~~a~~Authorizations for outpatient drugs within 24 hours as described in 42 CFR 438.210(d)(3) and section 1927(d)(5) of the Social Security Act. This shall include one attempt within the first 24

hours to obtain additional necessary information if needed. An initial response shall include:¶

(i) ~~A written~~, telephonic or electronic communication of approval of the drug as requested to the ~~member, and~~ prescribing practitioner, and when known to the CCO, the pharmacy; or.¶

(ii) A written notice of adverse benefit determination of the drug per OAR 410-141-3885 to the ~~mCCO Member~~, and telephonic or electronic notice to the prescribing practitioner, and when known to the CCO, the pharmacy if the drug is denied or partially approved; or.¶

(iii) A written, telephonic, or electronic request for additional documentation to the prescribing practitioner when the ~~pPrior a~~Authorization request lacks the CCO's standard information collection tools such as ~~pPrior a~~Authorization forms or other documentation necessary to render a decision; or.¶

(iv) A written, telephonic, or electronic acknowledgment of receipt of the ~~pPrior a~~Authorization request that gives an expected timeframe for a decision. An initial response indicating only acceptance of a request must not delay a decision to approve or deny the drug within 72 hours.¶

(B) The 72-hour window for a coverage decision begins with the initial date and time stamp of a ~~pPrior a~~Authorization request for a drug;¶

(C) If the response is a request for additional documentation, the CCO shall identify and notify the prescribing practitioner of the documentation required to make a coverage decision and comply within the following timeframes:¶

(i) Upon receiving the CCO's completed ~~pPrior a~~Authorization forms and required documentation, the CCO shall issue a decision as expeditiously as the ~~mCCO Member's~~ health requires, but no later than 72 hours from the date and time stamp of the initial request for ~~pPrior a~~Authorization as follows:¶

(I) If the drug is approved as requested, the CCO shall ~~notify the member in writing and~~ provide a telephonic or electronic communication to the prescribing practitioner, and when known to the CCO, the pharmacy; ~~telephonically, or electronically;~~ or.¶

(II) If the drug is denied or partially approved, the CCO shall issue a written notice of adverse benefit determination to the ~~mCCO Member~~, and telephonic or electronic notice to the prescribing practitioner, and when known to the CCO, the pharmacy.¶

(ii) If the requested additional documentation is not received within 72 hours from the date and time stamp of the initial request for ~~pPrior a~~Authorization, the CCO shall issue a written notice of adverse benefit determination to the ~~mCCO Member~~, and telephonic or electronic notice to the prescribing practitioner, and when known to the CCO, the pharmacy.¶

(D) The CCO shall provide approved services as expeditiously as the ~~mCCO Member's~~ health condition requires;¶

(E) If an emergency situation justifies the immediate medical need for the drug during this review process, an emergency supply of 72 hours or longer shall be made available until the CCO makes a coverage decision.¶

(c) For HRSN ~~s~~Services, the CCO shall comply with the service authorization timelines in OAR 410-120-2020.¶

(d) For ~~mCCO Members~~ with ~~s~~Special ~~H~~Health ~~e~~Care ~~n~~Needs, as determined through an assessment requiring a course of treatment or regular care monitoring, each CCO ~~shall~~ must have a mechanism in place to allow ~~mCCO Members~~ to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the ~~mCCO Member's~~ condition and identified needs;¶

(e) Any service authorization decision not reached within the timeframes specified in this rule shall constitute a denial and becomes an adverse benefit determination. A notice of adverse benefit determination shall be issued on the date the timeframe expires;¶

(f) CCOs shall give the ~~mCCO Members~~ written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet the requirements of CFR § 438.404 and OAR 410-141-3885;¶

~~(g) The CCO and its subcontractors shall have and follow written policies and procedures to ensure consistent application of review criteria for service authorization requests including~~ 13) CCOs must have written policies and procedures to ensure their personnel and any applicable subcontractors review service authorization requests consistently. In addition to the CCO's own criteria, the policies and procedures must include the following:¶

~~(Aa) For medical, behavioral, or oral health~~ Covered Sservices;¶

~~(iA) The CCOs shall consult with the requesting pProvider for medical, behavioral, or oral health services when necessary; s when:~~¶

(i) The CCO requires more information to make a Medical Necessity and Medical Appropriateness determination; or¶

(ii) As may be requested by the Provider.¶

~~(4B) R~~CCOs must requesting all the appropriate information to support decision making as early in the review process as possible; and.¶

~~(4) Adding C) CCOs must~~ documentation in the authorization file on outreach methods and dates when the methods used to contact the Provider and dates on which the CCO requested additional information was requested from

the requesting ~~p~~Provider. ¶

~~(ii) Decisions~~ (b) All decisions (as defined below in subsection (d) of this section (13)) shall be made by an individual who has clinical expertise in addressing the member's medical, behavioral, or oral health needs or in consultation with a health care professional with clinical expertise in treating the member's condition or disease. This applies to decisions to: Any decision to deny a CCO Member's service authorization request, in full or in part, must be made by a clinician who possesses one of the licenses or certifications listed below that is issued by the applicable Oregon licensing board or Oregon certifying body or organization and that clinician's scope of practice includes the provision of the service(s) that would address the requesting CCO Member's condition. ¶

(A) Medical, including durable medical equipment: Physicians (Degree types: MD, DO, ND, and MBBS), Nurse Practitioners, certified physician associates. ¶

(B) Psychological and psychiatric healthcare: Physicians (Degree types: MD, DO, ND, and MBBS), Nurse Practitioners, certified physician associates and doctoral-level clinical psychologists and Clinical Social Workers. In addition, licensed master's level therapists (i.e. LMFT, LPC, LCSW) may deny mental health therapy services. ¶

(C) Substance use disorder healthcare: Physicians (Degree types: MD, DO, ND, and MBBS), Nurse Practitioners, certified physician associates, doctoral-level clinical psychologists and Clinical Social Workers. In addition, licensed master's level therapists (i.e. LMFT, LPC, LCSW) who have working knowledge of the American Society of Addiction Medicine Placement (ASAM) criteria may deny substance health therapy services. ¶

(D) Pharmaceutical: Pharmacists, Physicians (Degree types: MD, DO, ND, and MBBS), Nurse Practitioners, certified physician associates. ¶

(E) Dental: Dentists (Degree types: DDS, DMD). ¶

(F) Chiropractic: Chiropractors, Physicians (Degree types: MD, DO, ND, and MBBS). ¶

(G) Acupuncture: Acupuncturists, traditional Chinese medicine clinicians, Physicians (Degree types: MD, DO, ND, and MBBS), Nurse Practitioners, certified physician associates. ¶

(H) Physical therapy: Physical Therapists, Physicians (Degree types: MD, DO, ND, and MBBS), Nurse Practitioners, certified physician associates. ¶

(I) Applied behavioral analysis: doctoral-level board-certified behavioral analysts, Physicians (Degree types: MD, DO, ND, and MBBS), Nurse Practitioners, certified physician associates, doctoral-level clinical psychologists and Clinical Social Workers. ¶

(c) The CCO shall escalate the review of the service authorization request to a clinician(s) with additional expertise when it is warranted because the CCO Member's health condition is clinically complex. ¶

(d) Decisions as used in (13)(b) refers to the following: ¶

~~(A) Denial of a service authorization request; ¶~~

~~(B) Reduction of a previously authorized service request; or ¶~~

~~(C) Authorization of a service in an amount, duration, or scope that is less than requested. ¶~~

~~(B) ¶~~

(e) Documentation shall be completed to support the determination of whether the requested service(s) is Medically Necessary and Medically Appropriate as defined in 410-120-0000. This documentation must: ¶

(A) Be logged in the Grievance and Appeals System; ¶

(B) Be provided to the Authority upon request within five (5) business days; and ¶

(C) Where applicable for decisions (as defined above in subsection (d) of this section (13)), be sufficient such that the Authority is capable of verifying that the CCO considered clinical factors, including but not limited to Comorbidities, during an individual medical necessity review, as described in 410-141-3820(13). ¶

(f) For HRSN Services, the CCO shall comply with OAR 410-120-2020. ¶

~~(g) CCOs shall have written policies and procedures for processing prior authorization requests received from any ~~p~~Provider. The policies and procedures shall specify timeframes for the following: ¶~~

~~(A) Date and time stamping prior authorization requests when received; ¶~~

~~(B) Determining within a specific number of days from receipt whether a ~~p~~Prior ~~a~~Authorization request is valid or non-valid; ¶~~

~~(C) The specific number of days allowed for follow-up on pended ~~p~~Prior ~~a~~Authorization requests to obtain additional information; ¶~~

~~(D) The specific number of days following receipt of the additional information that an approval or denial shall be issued; ¶~~

~~(E) Providing services after office hours and on weekends that require ~~p~~Prior ~~a~~Authorization. ¶~~

~~(h) A CCO shall make a determination on at least 95 percent of valid ~~p~~Prior ~~a~~Authorization requests within two (2) business days of receipt of a ~~p~~Prior ~~a~~Authorization or reauthorization request related to: ¶~~

~~(A) Drugs; ¶~~

~~(B) Alcohol; ¶~~

~~(C) Drug services; or ¶~~

~~(iv)~~ (D) Care required while in a skilled nursing facility.¶

(134) Report to the Authority annually requests for ~~p~~Prior ~~a~~Authorization. The report shall include:¶

(a) The number of requests received;¶

(b) The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or failure to provide additional clinical information requested by the insurer;¶

(c) The number of requests that were initially approved; and¶

(d) The number of denials that were reversed by internal ~~a~~Appeals or external reviews.

Statutory/Other Authority: ORS 413.042, 414.065, 414.572, 414.591, 414.605

Statutes/Other Implemented: ORS 414.065, 414.570-414.686

RULE SUMMARY: Clarify that reimbursement is required for Medically Necessary or Medically Appropriate drugs, subject to exclusions and limitations. Replace references to a "member" with "CCO Member." Capitalize defined terms.

CHANGES TO RULE:

410-141-3855

Pharmaceutical Services

(1) ~~Prescription drugs are a covered service for conditions that are described in the funded region of the Prior~~ CCOs shall reimburse for Medically Necessary and Medically Appropriate prescriptized List of Health Services, as described in OAR 410-141-3820. MCEs shall pay for covered prescription drugs on drugs, including as applicable and specified in OAR 410-141-3820, except:

(a) As otherwise provided, mental health drugs that are in Standard Therapeutic Class 7 (ataractics-tranquilizers) or Standard Therapeutic Class 11 (psychostimulants-antidepressants) (based on the National Drug Code (NDC) as submitted by the manufacturer to First Data Bank); and are dispensed through a licensed pharmacy;

(b) FDA-approved formulations of valproic acid and its derivatives, lamotrigine, and xanomeline/trospium and those drugs used to treat severe mental health conditions that the Authority specifically carved out from capitation according to section (11) of this rule; This only includes those prescription drugs dispensed through a licensed pharmacy;

(c) Drugs covered under Medicare Part D when the ~~m~~CCO Member is fully dual eligible; and

(d) Prescriptions for Physician Assisted Suicide under the Oregon Death with Dignity Act, for which payment is governed by OAR 410-121-0150.

(e) Drugs appearing on the High-Cost Drug Carve-Out (HCDCO) List dated ~~25~~1/2026, appearing at www.orpdl.org, and included here by reference. ~~MCE~~CCOs will be responsible for all other associated costs, including non-emergency medical transportation, care coordination, inpatient hospital services and other ~~m~~Medically ~~n~~Necessary expenses.

(A) The HCDCO List is limited to drugs determined by the Authority to present extreme financial uncertainty for CCOs. Drugs meeting the following general criteria will be considered by the Authority for inclusion on the HCDCO List:

(i) Have an estimated acquisition cost of \$500,000 or more per member over a 12-month period;

(ii) Are indicated for very rare conditions; and

(iii) Have few alternatives, as determined by the Authority.

(B) To add a drug to or remove a drug from the HCDCO List:

(i) ~~The MCE, the CCO~~ shall submit a request to the Authority containing all the following information:

(i) The drug name;

(ii) Whether the drug is recommended to be added to or removed from the HCDCO List;

(iii) The estimated per member acquisition cost of the drug for a 12-month period;

(iv) The FDA-approved indications for the drug;

(v) Any alternative treatments to the drug for these indications; and

(vi) Any additional considerations the Authority should give to adding or removing the drug;

such as how the drug presents a financial risk to the CCO which is not adequately contemplated in current capitation rates.

(C) If the Authority approves an ~~MCE~~CCO request for a drug to be added to or removed from the HCDCO List, the Authority shall revise the HCDCO List and amend subsection (e) of this section (1) according to the rulemaking process described in ORS 183.333-183.335 ~~effective no later than:~~

(I) ~~The following January 1st, for requests submitted between January 15th – July 14th;~~

(II) ~~The following July.~~

(i) For existing drugs whose carve out will have an impact on capitation rates as determined by OHA, the effective date of the change will be:

(I) The following January 1st, for requests submitted before April 1st; or

(II) One year from the following January 1st, for requests submitted on or after April 1st.

(ii) For new drugs or drugs whose carve out will not have an impact on capitation rates as determined by OHA, the effective date of the change will be:

(I) The following May 1st, for requests submitted before April 1st;

(II) The following August 1st, for requests submitted before July 1st;

(III) The following November 1st, for requests submitted between July 15th – fore October 1st;

(IV) The following February 1st, for requests submitted before January 14th.

~~(iii)st.~~

- (D) The Authority may add a drug to or remove a drug from the HCDCO List at any time using the rulemaking process described in ORS 183.333-183.335.¶
- (2) ~~MCE~~CCOs may use the statewide Practitioner-Managed Prescription Drug Plan under ORS 414.330 to 414.337.¶
- (3) ~~MCE~~CCOs may use a preferred drug list if it allows access to other drug products not on the drug list through ~~pPrior a~~Authorization.¶
- (4) As specified in 45 CFR 156.122 and 42 CFR 438.10, ~~MCE~~CCOs shall publish up-to-date, accurate, and complete preferred drug lists, including any tiering structures, that have been adopted and any coverage criteria or other restrictions on the way certain drugs may be obtained. ~~MCE~~CCOs shall ensure that:¶
- (a) The preferred drug list is easily accessible to ~~m~~CCO Members and potential members, state and federal government, and the public;¶
- (b) The preferred drug list is accessible on the ~~MCE~~CCO's public website in a machine-readable format through a clearly identifiable web link or tab without requiring a ~~m~~CCO Member to access account or policy number;¶
- (c) Be made available in paper form if requested by a ~~m~~CCO Member; and,¶
- (d) If an ~~MCE~~CCO has more than one plan, ~~m~~CCO Members may be easily able to discern which preferred drug list applies to which plan.¶
- (5) The preferred drug list shall:¶
- (a) Include Federal Drug Administration (FDA) approved drug products for each therapeutic class sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the ~~p~~Provider of pharmaceutical services;¶
- (b) Include at least one item in each therapeutic class of over-the-counter medications; and,¶
- (c) Be revised periodically to assure compliance with this requirement.¶
- (6) ~~MCE~~CCOs shall cover at least one form of contraception within each of the 18 methods identified by the FDA. As set forth in OAR 410-141-3515, the ~~m~~CCO Member may refer themselves directly to family planning services without getting a referral from a PCP or other ~~p~~Participating ~~p~~Providers.¶
- (7) Prior Authorization for prescription drug requests shall be addressed by the ~~MCE~~CCOs as described in OAR 410-141-3835.¶
- (8) ~~MCE~~CCOs shall authorize the provision of a drug requested by the Primary Care Provider or referring ~~p~~Provider if the prescriber certifies medical necessity for the drug such as:¶
- (a) The equivalent of the drug listed has been ineffective in treatment; or,¶
- (b) The drug listed causes or is reasonably expected to cause adverse or harmful reactions to the ~~m~~CCO Member.¶
- (9) ~~MCEs may~~CCOs must not authorize payment for any Drug Efficacy Study Implementation (DESI) Less Than Effective (LTE) drugs that have reached the FDA Notice of Opportunity for Hearing (NOOH) stage, as specified in OAR 410-121-0420 (DESI)(LTE) Drug List. DESI LTE drugs are identified by the Covered Outpatient Drug (COD) Status equal to 05 or 06 in the federal "Drug Products in the Medicaid Drug Rebate Program" list available at: <https://data.medicaid.gov/>¶
- (10) The Authority shall pay for a drug that is not included in the global budget pursuant to the Pharmaceutical Services program rules (chapter 410, division 121), unless otherwise provided in this rule. ~~An MCE may~~CCO must not reimburse ~~p~~Providers for drugs carved-out in section (1) of this rule.¶
- (11) Making changes to the carve-out list of mental health drugs in subsection (1)(b) of this rule:¶
- (a) Adding mental health drugs to the carve-out list.¶
- (A) ~~An MCE~~CCO may seek to add drugs by submitting a request to the Authority. The request must contain all the following information:¶
- (i) The drug name;¶
- (ii) The FDA-approved indications that identify the drug may be used to treat a severe mental health condition, along with any other FDA-approved indications; and,¶
- (iii) The reason the Authority should consider this drug for carve out.¶
- (B) If the Authority approves an ~~MCE~~CCO request for a drug not to be paid within the global budget, the Authority shall:¶
- (i) Amend subsection (1)(b) of this rule according to the process described in ORS 183.335(5) within sixty (60) days of the request to exclude the drug from the global budget if the Authority determines that the drug has an approved FDA indication for the treatment of a severe mental health condition such as major depressive, bi-polar, or schizophrenic disorders;¶
- (ii) Within 180 days of amending subsection (1)(b) of this rule as described in subsection (i), adopt this same amendment to subsection (1)(b) using the permanent rulemaking process described in ORS 183.335(1)-(4).¶
- (C) The Authority may add drugs at any time using the rulemaking process described in ORS 183.333-183.335.¶
- (b) Removing mental health drugs from the carve-out list.¶
- (A) ~~An MCE~~CCO may seek to remove drugs by submitting a request to the Authority no later than March 1 of any contract year. The request must contain all the following information:¶

- (i) The drug name;¶
 - (ii) The FDA approved indications for the drug; and.¶
 - (iii) The reason the Authority should consider removing this drug from the list of carved out drugs.¶
 - (B) If the Authority approves an ~~MCE~~ CCO request for a carved-out drug to be paid within the global budget, the Authority shall include the drug in the global budget for the following January contract cycle.¶
 - (C) The Authority may remove drugs in conjunction with a January contract cycle using the rulemaking process described in ORS 183.333-183.335.¶
 - (12) ~~MCE~~ CCOs shall submit quarterly encounter data within 45 days after the end of the quarter pursuant to 42 CFR 438.3.¶
 - (13) ~~MCE~~ CCOs are encouraged to provide payment only for outpatient and physician-administered drugs produced by manufacturers that have valid rebate agreements in place with the CMS as part of the Medicaid Drug Rebate Program. ~~MCE~~ CCOs may continue to have some flexibility in maintaining preferred drug lists regardless of whether the manufacturers of those drugs participate in the Medicaid Drug Rebate Program.¶
 - (14) ~~MCE~~ CCOs shall utilize a Pharmacy and Therapeutics (P&T) committee and a Drug Use Review (DUR) program. The committees may work in tandem or independent of the other, if all committee requirements for both committee types are met:¶
 - (a) A P&T committee must maintain written documentation of the rationale for all decisions regarding the drug list development and revisions. The committee shall follow the membership and meeting standards specified in 45 CFR § 156.122(3)(i) and (ii). Meetings shall be held at least quarterly;¶
 - (b) ~~MCE~~ CCOs shall provide a detailed description of its P&T committee including its DUR functions on an annual basis. The report shall be in the form and manner required by the OHP. The data requested by the Authority shall be calculated to meet federal reporting obligations;¶
 - (c) The committee in its DUR capacity shall assure prescriptions are appropriate, ~~medically appropriate~~, and not likely to result in adverse medical results. The committee must be designed to educate prescribers and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. The committee shall include prospective DUR, retrospective DUR, and educational programs as each is defined and described by 42 CFR 456, subpart K and Section 1902(o) of the Social Security Act [42 U.S.C. 1396a(o)].¶
 - (15) As required by ORS 414.328, CCOs shall implement a synchronization policy for the dispensing of prescription drugs to members of the CCO. A "synchronization policy" means a procedure for aligning the refill dates of a patient's prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently.¶
 - (16) Enrolled ~~p~~ Providers are required to check the Prescription Drug Monitoring Program (PDMP) as defined in ORS 431A.655 before prescribing a schedule II controlled substance pursuant to 42 U.S.C 1396w-3a:¶
 - (a) Providers shall maintain documentation of the prescription drug history of the individual being treated; and.¶
 - (b) In the case that an enrolled ~~p~~ Provider is not able to conduct the PDMP check, the ~~p~~ Providers shall maintain documentation of efforts, including reasons why the ~~p~~ Provider was unable to conduct the check;¶
 - (c) The PDMP check does not apply to clients in exempt populations:¶
 - (A) Individuals receiving hospice care;¶
 - (B) Individuals receiving palliative care;¶
 - (C) Individuals receiving cancer treatment;¶
 - (D) Individuals with sickle cell disease;¶
 - (E) Residents of long-term care facilities described in ~~42 U.S.C. 1396d~~, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy in accordance with 42 U.S.C. 1396w-3a(h)(2)(B); and.¶
 - (F) Individuals admitted to an inpatient hospital facility. This exemption shall only apply to schedule II controlled substances provided or administered to the individual admitted to the inpatient hospital facility.¶
 - (d) PDMP requirements are in accordance with OAR 333-023-0800 to 333-023-0830.
- Statutory/Other Authority: ORS 413.042, 414.572, 414.591, 414.605
- Statutes/Other Implemented: ORS 414.570-414.686

RULE SUMMARY: Describe individual medical necessity review requirements. Clarify requirements for NOABDs following a denial for a claim. Replace references to a "member" with "CCO Member." Replace references to an "managed care entity" or "MCE" with a "coordinated care organization" or "CCO."

Capitalize defined terms.

CHANGES TO RULE:

410-141-3885

Grievances & Appeals: Notice of Action/Adverse Benefit Determination

- (1) When a ~~Managed Care Entity (MCE)~~Coordinated Care Organization (CCO) has made an ~~adverse benefit~~Adverse Benefit ~~determination~~Determination, the ~~MCE~~CCO shall give the requesting ~~provider~~Provider, the CCO Member and the ~~CCO Member's~~CCO Member's ~~Representative~~Representative a written Notice of Adverse Benefit Determination (NOABD). The notice shall: ¶
- (a) Comply with the Authority's formatting and readability standards in OAR 410-141-3585 and 42 CFR § 438.10 and be written in plain language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an ~~appeal~~Appeal; ¶
- (b) For timing of notices, follow timelines required for the specific service authorization or type via oral and written mechanisms for any service request of the ~~CCO Member~~CCO Member or the ~~CCO Member's~~CCO Member's ~~provider~~Provider outlined in OAR 410-141-3835 ~~MCE~~CCO Service Authorization or otherwise specified in this rule. ¶
- (2) The following are notice requirements for preservice denials: ¶
- (a) Meet the content notice requirements specified in 42 CFR § 438.404 and in the ~~MCE~~CCO contract, including the following information: ¶
- (A) ~~MCE~~CCO contact information and subcontractor contact information including name, address, and telephone number, if applicable, included in the ABD notice excluding any cover pages; ¶
- (B) Date of the notice; ¶
- (C) For notices not pertaining to non-emergency ~~medical transportation (NEMT)~~medical transportation (NEMT) services, the name of the ~~CCO Member's~~CCO Member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or Behavioral Health (BH) professional if the ~~CCO Member~~CCO Member has an assigned ~~practitioner~~Practitioner or the most specific information available if a ~~CCO Member~~CCO Member is not assigned to a ~~practitioner~~Practitioner due to the clinic/facility model. If the ~~CCO Member~~CCO Member has not been assigned a ~~practitioner~~Practitioner because they enrolled in the MCE within the last ninety (90) days, the NOABD shall state PCP, PCD, BH ~~provider~~Provider assignment has not occurred; ¶
- (D) CCO Member's name, date of birth, address, and OHP member ID number; ¶
- (E) Service requested and the adverse benefit determination the ~~MCE~~CCO intends to make, including whether the ~~MCE~~CCO is denying, (in whole or part) terminating, suspending, or reducing a service; ¶
- (F) Date service was requested by the provider or ~~CCO Member~~CCO Member; ¶
- (G) Name of the ~~provider~~Provider who requested the service; ¶
- (H) Effective date of the ~~adverse benefit~~Adverse Benefit ~~determination~~Determination if different from the date of the notice; ¶
- (I) Diagnosis and procedure codes submitted with the authorization request including a description of all codes in plain language. For services that do not include a procedure code a description of the requested service; ¶
- (J) Whether the ~~MCE~~CCO considered ~~other conditions such as co-morbidity factors if the condition was below the funding line on the Prioritized List of Health Services~~clinical factors including but not limited to Comorbidities during an individual medical necessity review pursuant to OAR 410-141-3820 and ~~410-141-3830(13)~~; ¶
- (K) Clear and thorough explanation of the specific reasons for the ~~adverse benefit~~Adverse Benefit ~~determination~~Determination. If the service has been denied as the ~~provider~~Provider did not submit the supporting documentation include a statement in the NOABD that before denying the requested service attempts by the ~~MCE~~CCO have been made to obtain the documentation from the ~~provider~~Provider; ¶
- (L) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the NOABD; ¶
- (M) The CCO Member, ~~CCO Member's~~CCO Member's ~~Representative~~Representative or, the ~~provider~~Provider with the ~~CCO Member's~~CCO Member's written consent as required under OAR 410-141-3890(1), may file a written or oral ~~appeal~~Appeal of the ~~MCE~~CCO's ~~adverse benefit~~Adverse Benefit ~~determination~~Determination with the ~~MCE~~CCO within sixty (60) days from the date of the NOABD, including information on exhausting the ~~MCE~~CCO's one level of ~~appeal~~Appeal, and the procedures to exercise that right; ¶
- (N) The CCO Member, ~~CCO Member's~~CCO Member's ~~Representative~~Representative or the ~~provider~~Provider with the ~~CCO Member's~~CCO Member's written consent has the right to request a ~~contested case~~Contested Case ~~hearing~~Hearing either orally or in writing with the Authority 120 days from the date of the ~~MCE~~CCO's Notice of Appeal Resolution or where the ~~MCE~~CCO failed to meet ~~appeal~~Appeal timelines (standard ~~appeal~~Appeal sixteen (16) days to review and resolve ~~appeal~~Appeal from date of receipt with a possible fourteen (14) day extension OAR 410-141-3890, expedited ~~appeal~~Appeal 72 hours to review and resolve ~~appeal~~Appeal from

date of receipt with a possible fourteen (14) day extension OAR 410-141-3895), and the procedures to exercise that right;¶

(O) The circumstances under which an ~~a~~Appeal process or ~~e~~Contested ~~e~~Case ~~h~~Hearing can be expedited and how the CCO Member, ~~m~~CCO Member ~~r~~Representative or the ~~m~~CCO Member's ~~p~~Provider may request it. If the ~~MCECCO~~ denies a request for an expedited ~~a~~Appeal, it shall be transferred to the standard ~~a~~Appeal resolution timeframes;¶

(P) The ~~m~~CCO Member's right to have benefits continue pending resolution of the ~~a~~Appeal or ~~e~~Contested ~~e~~Case ~~h~~Hearing and that continued benefits can be requested by the CCO Member or ~~m~~CCO Member's ~~r~~Representative. The timeframes to request that benefits be continued and the circumstances under which the ~~m~~CCO Member may be required to pay the cost of these services as described in OAR 410-141-3910 ;¶

(Q) The ~~m~~CCO Member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the ~~m~~CCO Member's ~~a~~Adverse ~~b~~Benefit ~~d~~Determination including any processes, strategies, or evidentiary standards used by the MCE in setting coverage limits or making the ~~a~~Adverse ~~b~~Benefit ~~d~~Determination;¶

(R) Information on requesting help and who to contact;¶

(S) To support their ~~a~~Appeal, the ~~m~~CCO Member's right to give information and testimony in person or in writing, and make legal and factual arguments in person or in writing within the ~~a~~Appeal timelines; and ¶

(T) Inclusion of the names of ~~p~~Providers, clinics or ~~m~~CCO Member's ~~r~~Representative copied on the notice;¶

(b) Use an Authority approved NOABD notice form unless the ~~m~~CCO Member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in the NOABD.¶

(3) The following are notice requirements for post service denials:¶

(a) Meet the content notice requirements specified in 42 CFR § 438.404 and in the ~~MCECCO~~ contract, including the following information:¶

(A) ~~MCECCO~~ contact information including name, address, and telephone number and subcontractor contact information, if applicable, included in the NOABD excluding any cover pages;¶

(B) Date of the notice;¶

(C) For notices not pertaining to non-emergency medical transportation (NEMT) services, the name of the ~~m~~CCO Member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or Behavioral Health (BH) professional if the ~~m~~CCO Member has an assigned ~~p~~Practitioner or the most specific information available if a ~~m~~CCO Member is not assigned to a ~~p~~Practitioner due to the clinic/facility model. If the CCO member has not been assigned a ~~p~~Practitioner because they enrolled in the ~~MCECCO~~ within the last ninety (90) days, the NOABD shall state PCP, PCD, BH ~~p~~Provider assignment has not occurred;¶

(D) CCO Member's name, D.O.B, address, and OHP member ID number;¶

(E) Service previously provided in plain language and the ~~a~~Adverse ~~b~~Benefit ~~d~~Determination the ~~MCECCO~~ made;¶

(F) Date the service was provided;¶

(G) Name of the ~~p~~Provider who provided the service;¶

(H) Effective date (date claim denied) of the ~~a~~Adverse ~~b~~Benefit ~~d~~Determination if different from the date of the notice;¶

(I) Diagnosis and procedure codes submitted on the claim including a description of all codes in plain language. For services that do not include a procedure code a description of the service provided in plain language;¶

(J) ~~Whether the MCE considered other conditions such as co-morbidity factors if the condition was below the funding line on the Prioritized List of Health Services and other services pursuant to OAR 410-141-3820 and 410-141-3830. NOABD shall clearly indicate whether a medical review was performed and if not that the provider can resubmit claim with chart notes for review of comorbidity; NOABD shall clearly indicate whether a medical review was performed;¶~~

(K) Clear and thorough explanation of the specific reasons for the ~~a~~Adverse ~~b~~Benefit ~~d~~Determination. If the service has been denied as the ~~p~~Provider did not submit the supporting documentation include a statement in the NOABD that before denying the requested service attempts by the ~~MCECCO~~ have been made to obtain the documentation from the ~~p~~Provider;¶

(L) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the ABD notice;¶

(M) The CCO Member, ~~m~~CCO Member ~~r~~Representative or, the ~~p~~Provider with the ~~m~~CCO Member's written consent as required under OAR 410-141-3890(1), may file a written or oral ~~a~~Appeal of the ~~MCECCO~~'s adverse benefit determination with the ~~MCECCO~~ within 60 days from the date of the NOABD, including information on exhausting the ~~MCECCO~~'s one level of ~~a~~Appeal, and the procedures to exercise that right;¶

(N) The CCO Member, ~~m~~CCO Member ~~r~~Representative or the ~~p~~Provider with the ~~m~~CCO Member's written consent has the right to request a ~~e~~Contested ~~e~~Case ~~h~~Hearing either orally or in writing with the Authority 120 days from the date of the ~~MCECCO~~'s Notice of Appeal Resolution or where the ~~MCECCO~~ failed to meet ~~a~~Appeal

timelines (standard ~~a~~Appeal 16 days to review and resolve ~~a~~Appeal from date of receipt with a possible fourteen (14) day extension 410-141-3890, expedited ~~a~~Appeal seventy two (72) hours to review and resolve ~~a~~Appeal from date of receipt with a possible 14 day extension 410-141-3895) and the procedures to exercise that right; ¶

(O) An explanation to the ~~m~~CCO Member that there are circumstances under which an ~~a~~Appeal process or ~~e~~Contested ~~e~~Case ~~h~~Hearing can be expedited and how the ~~CCO~~ Member, ~~m~~CCO Member ~~r~~Representative or the ~~m~~CCO Member's ~~p~~Provider may request it, but that an expedited ~~a~~Appeal and hearing shall not be granted for post-service denials as the service has already been provided; ¶

(P) The ~~m~~CCO Member's right to have benefits continue pending resolution of the ~~a~~Appeal or ~~e~~Contested ~~e~~Case ~~h~~Hearing and that continued benefits can be requested by the ~~CCO~~ Member or ~~m~~CCO Member's ~~r~~Representative. The timeframes to request that benefits be continued and the circumstances under which the ~~m~~CCO Member may be required to pay the cost of these services as described in OAR 410-141-3910 ; ¶

(Q) The ~~m~~CCO Member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the ~~m~~CCO Member's ~~a~~Adverse ~~b~~Benefit ~~d~~Determination including any processes, strategies, or evidentiary standards used by the ~~MCECCO~~ in setting coverage limits or making the adverse benefit determination; and ¶

(R) A statement that the ~~p~~Provider cannot bill the ~~m~~CCO Member for a service rendered unless the ~~m~~CCO Member signed an OHP Agreement to Pay form (OHP 3165 or 3166); ¶

(S) To support their ~~a~~Appeal, the ~~m~~CCO Member's right to give information and testimony in person or in writing, and make legal and factual arguments in person or in writing within the ~~a~~Appeal timelines; ¶

(T) Information on requesting help and who to contact; and ¶

(U) Inclusion of the names of ~~p~~Providers, clinics or ~~m~~CCO Member's ~~r~~Representative copied on the notice. ¶

(b) Use an Authority approved form unless the ~~m~~CCO Member is a dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in the NOABD. ¶

(4) The ~~MCECCO~~ shall provide a copy of the Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302) or approved facsimile when an NOABD is issued. ¶

(5) The ~~MCECCO~~ may provide a copy of the Non-Discrimination Policy when an NOABD is issued. ¶

(6) For requirements of NOABD that affect services previously authorized, the ~~MCECCO~~ shall mail the notice at least ten (10) days before the date the ~~a~~Adverse ~~b~~Benefit ~~d~~Determination reduction, termination, or suspension takes effect, as referenced in 42 CFR 431.211. ¶

(7) In 42 CFR §§ 431.213 and 431.214, exceptions related to advance notice include the following: ¶

(a) The ~~MCECCO~~ may mail the notice no later than the date of adverse benefit determination if: ¶

(A) The ~~MCECCO~~ has factual information confirming the death of the ~~m~~CCO Member; ¶

(B) The ~~MCECCO~~ receives a signed, written notice from the ~~m~~CCO Member that the services previously requested are no longer desired and clearly indicates the ~~m~~CCO Member understands that the services previously requested shall be terminated or reduced as a result of the notice; ¶

(C) The ~~MCECCO~~ may verify that the ~~m~~CCO Member has been admitted to an institution where the ~~m~~CCO Member is no longer eligible for OHP services from the ~~MCECCO~~; ¶

(D) The ~~MCECCO~~ is unaware of the ~~m~~CCO Member's location and the ~~MCECCO~~ receives returned mail directed to the ~~m~~CCO Member from the post office indicating no forwarding address and the Authority or Department has no other address; ¶

(E) The ~~MCECCO~~ verifies another state, territory, or commonwealth accepted the ~~m~~CCO Member for Medicaid services; or ¶

(F) The ~~m~~CCO Member's PCP, PCD, or behavioral health professional prescribed a change in the level of health services. ¶

(b) The ~~MCECCO~~ must mail the notice five days before the ~~a~~Adverse ~~b~~Benefit ~~d~~Determination when the ~~MCECCO~~ has: ¶

(A) Facts indicating that an ~~a~~Adverse ~~b~~Benefit ~~d~~Determination may be taken because of probable fraud on part of the ~~m~~CCO Member; and ¶

(B) Verified those facts, whenever possible, through secondary resources. ¶

(c) For denial of payment, the ~~a~~Adverse ~~b~~Benefit ~~d~~Determination shall be mailed at the time of any ~~a~~Adverse ~~b~~Benefit ~~d~~Determination that affects the claim. ¶

(8) Within sixty (60) days from the date on the notice: The ~~m~~CCO Member or ~~p~~Provider may file an ~~a~~Appeal; the ~~m~~CCO Member may request a Contested Case Hearing with the Authority after receiving notice that the ~~MCECCO~~'s ~~a~~Adverse ~~b~~Benefit ~~d~~Determination is upheld; or if the ~~MCECCO~~ fails to adhere to the notice and timing requirements in 42 CFR 438.408, the Authority may consider the ~~MCECCO~~ Appeals process exhausted.

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0000

RULE SUMMARY: Update OAR reference to OAR 410-141-3830. Update reference to the OHA Prioritized List. Replace references to a "client" with "Member." Capitalize defined terms.

CHANGES TO RULE:

410-146-0000

Foreword ¶

(1) ~~The Health Systems Division (Division)~~ Division American Indian/Alaska Native (AI/AN) Oregon Administrative Rules are designed to assist the following ~~pp~~ Providers to prepare claims for services provided to ~~client~~ Members with Medical Assistance Program coverage: ¶

(a) Indian Health Service (IHS) facilities; and ¶

(b) Tribal 638 facilities, defined as Tribally-operated health care clinics owned or operated by a Tribe or Tribal organization with funding authorized by Title I or Title V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), and recognized by the Centers for Medicare and Medicaid Services (CMS) under the 1996 Memorandum of Agreement (MOA); ¶

(2) ~~Indian Health Care Providers (IHCP)~~ not designated an IHS or Tribal 638 facility should refer to Oregon Health Plan (OHP) ~~G~~general ~~R~~rules (~~OAR chapter 410, division 120~~) and other applicable program-specific rules to enroll and operate as any other ~~pp~~ Provider type recognized under the ~~s~~State ~~p~~Plan. ¶

(3) CMS does not recognize Urban Indian Health Program (UIHP) clinics as eligible for reimbursement of services under the MOA. UIHP ~~C~~clinics should refer to: ¶

(a) Federally Qualified Health Centers (FQHC) and Rural Health Clinics administrative Rules (~~OAR chapter 410, division 147~~) to enroll as a FQHC if the clinic is an urban Indian organization under the Indian Health Care Improvement Act, Public Law 94-437; or, ¶

(b) OHP ~~G~~general ~~R~~rules (~~OAR chapter 410, division 120~~) and other applicable program-specific rules to enroll and operate as any other ~~pp~~ Provider type recognized under the ~~s~~State ~~p~~Plan. ¶

(4) The AI/AN administrative rules include important information about general program policy, ~~pp~~ Provider enrollment, maintenance of financial records, special programs, and billing. Unless specifically directed by the AI/AN rules, do not use other Division administrative rules to determine appropriate action. ¶

(5) OHP-enrolled IHCP must use the OHP ~~G~~general ~~R~~rules (~~OAR chapter 410, division 120~~) and the OHP ~~A~~administrative ~~R~~rules (~~OAR chapter 410-D, division 141~~) as directed in the AI/AN rules and in conjunction with applicable program-specific rules including the AI/AN administrative rules. ¶

(6) ~~The Health Evidence Review Commission's~~ OHA Prioritized List of Health Services defines the Division's Medicaid-covered services. For more information, refer to ~~the OHP Administrative Rules (OAR 410-141-0520)~~ 3830.

Statutory/Other Authority: ORS 414.065

Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0080

RULE SUMMARY: Update OAR references (e.g., to OAR 410-141-3820). Update reference to the OHA Prioritized List. Replace references to a “client” with “Member.” Capitalize defined terms.

CHANGES TO RULE:

410-146-0080

Professional Ambulatory Services ¶¶

(1) Professional ~~A~~mbulatory services provided by IHCP include ~~M~~medical, Diagnostic, ~~S~~ervices, screening, ~~D~~ental, Vision ~~S~~ervices, Physical Therapy, Occupational Therapy, Podiatric ~~S~~ervices, Behavioral Health, Substance Use Disorder, Maternity Case Management, ~~S~~peech, ~~H~~earing, and Home Health ~~s~~Services. ¶

(2) Providers must use the following guidelines in conjunction with all individual program-specific Division administrative rules to determine service coverage and limitations for OHP ~~client~~Members according to their ~~b~~Benefit ~~p~~Packages: ¶

(a) American Indian/Alaska Native (AI/AN) Services administrative rules (~~OAR~~chapter 410, division 146), ¶

(b) General ~~R~~ules (~~OAR~~chapter 410, division 120); ¶

(c) OHP ~~A~~administrative ~~R~~ules (OAR 410-141-~~0483820~~, 410-141-~~05003825~~, and 410-141-~~0523830~~), and ¶

(d) The ~~Health Evidence Review Commission's (HERC)~~OHA Prioritized List of Health Services (~~OHA Prioritized~~ List). ¶

(3) IHS and Tribal 638 facilities may be reimbursed for covered professional services provided within the scope of the clinic and within the individual practitioner's scope of license or certification. See also AI/AN OAR 410-146-0085. ¶

(4) The ~~d~~Date of ~~s~~Service determines the appropriate version of the AI/AN Services ~~R~~ules, ~~G~~general ~~R~~ules, and the ~~HERC~~OHA Prioritized List that IHCPs should use to determine coverage.

Statutory/Other Authority: ORS 413.042, ORS 414.065

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Update OAR reference to OAR 410-141-3830. Update reference to the OHA Prioritized List. Clarified requirements for coverage of services to diagnose conditions. Replace references to a "client" with "Member." Capitalize defined terms.

CHANGES TO RULE:

410-146-0085

Encounter and Recognized Practitioners ¶

~~Encounter and Recognized Practitioners ¶~~

(1) The Division shall reimburse enrolled AI/AN ~~p~~Providers as follows: ¶

(a) For services, items, and supplies that meet the criteria of a valid encounter in sections (5) through (7) of this rule; ¶

(b) Reimbursement is limited to the Division's Medicaid-~~e~~Covered ~~s~~Services according to a ~~client~~Member's OHP ~~b~~Benefit ~~p~~Package. These services may include any services included in the State Plan under Title XIX or Title XXI of the Social Security Act and provided pursuant to the determinations, conditions, and requirements of the ~~Prioritized List of Health Services found in the Health Evidence Review Commission's~~OHA Prioritized List of Health Services (see OAR 410-141-~~0523830~~).-// ¶

(2) IHCPs reimbursed according to a cost-based rate under the Prospective Payment System (PPS) shall use OAR 410-147-0120, Encounter and Recognized Practitioners, in the Division's FQHC and RHC program. ¶

(3) IHCPs reimbursed according to the IHS rate are subject to the requirements of this rule. ¶

(4) Services provided to Citizenship Waived Medical (CWM) and Qualified Medicare Beneficiary (QMB) only ~~client~~Members are not billed according to encounter criteria and not reimbursed at the IHS encounter rate (refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System). ¶

(5) For the provision of services defined in Titles XIX and XXI and provided through an IHS or Tribal 638 facility, an "encounter" is defined as a face-to-face, telephone contact, or a prescription fill as defined in OAR 410-146-0085(8) between a health care professional and an eligible ~~OHP-client~~Member within a 24-hour period ending at midnight, as documented in the ~~client~~Member's medical record. Section (7) of this rule outlines limitations for telephone contacts that qualify as encounters. For purposes of this rule, face-to-face "encounter" includes services provided via a synchronous two-way audiovisual link between a patient and a ~~p~~Provider per 410-130-0610. ¶

(6) An encounter includes all services, items, and supplies provided to a ~~client~~Member during the course of an office visit and "incident-to" services (except as excluded in section (17) of this rule). The following services are inclusive of the visit with the core ~~p~~Provider meeting the criteria of a reimbursable valid encounter and are not reimbursed separately: ¶

(a) Drugs or medication treatments provided during the clinic visit, with the exception of contraception supplies and medications as costs for these items are excluded from the IHS encounter rate calculation (refer to OAR 410-146-0200, Pharmacy);. ¶

(b) Medical supplies, equipment, or other disposable products (e.g. gauze, Band-Aids, wrist brace); and. ¶

(c) Venipuncture for laboratory tests. ¶

(7) An IHS or Tribal 638 Pharmacy encounter is a separate encounter and not made in conjunction with a medical, behavioral health, substance use disorder, or dental visit or with any other non-pharmacy visit related to a covered benefit. ¶

(8) A single pharmacy encounter includes one prescription dispensed by one IHS or Tribal 638 Pharmacy to a Medicaid-eligible individual in a single 24-hour period ending at midnight. There is no limit on the number of encounters that may occur in the 24-hour period. The encounter rate is inclusive of dispensing services. ¶

(9) Telephone encounters qualify as a valid encounter for services provided in accordance with OAR 410-130-0595, Maternity Case Management; OAR 410-146-0200, Tribal Pharmacy; and OAR 410-130-0190, Tobacco Cessation (OAR 410-120-1200). Except as set forth below, Providers may not make telephone contacts at the exclusion of face-to-face visits. ¶

(a) Telephone encounters must include all the same components of the service as if provided face-to-face. ¶

(b) During a state of emergency of an epidemic outbreak of an infectious disease impacting the safety of public health, in accordance with the ~~Health Evidence Review Commission's~~OHA Prioritized List, guideline notes, and OAR 410-130-0610 (for dates of service on or before December 31, 2020) and OAR 410-120-1990 (for dates of service on or after January 1, 2021), telephonic evaluation management services, assessment and management services, and psychotherapy are appropriate to ensure access to care while avoiding and preventing unnecessary potential infectious exposure, and may be made in place of a face-to-face visit. ¶

(10) The following services may be Medicaid-~~e~~Covered ~~s~~Services according to an OHP ~~client~~Member's ~~b~~Benefit

~~Package~~ as a stand-alone service; however, when furnished as a stand-alone service, they are not reimbursable.¶

(a) Case ~~Management~~ ~~Services~~ for coordinating care for a ~~client~~ Member.¶

(b) Sign language and oral interpreter services.¶

(c) Supportive rehabilitation services including, but not limited to, environmental intervention, supported employment, or skills training and activity therapy to promote community integration and job readiness.¶

(11) IHCPs may provide certain services, items, and supplies that are prohibited from being billed under the health centers ~~Provider~~ enrollment and that require separate enrollment (see OAR 410-146-0021, AI/AN Provider Enrollment). These services include:¶

(a) Durable ~~Medical~~ ~~Equipment~~, ~~Prosthetics~~, ~~Orthotics~~, or medical supplies (DMEPOS) (e.g., diabetic supplies) not generally provided during the course of a clinic visit (refer to OAR chapter 410, division 122, DMEPOS).¶

(b) Prescription pharmaceuticals and biologicals not generally provided during the clinic visit that are dispensed by an IHS or Tribal 638 Pharmacy may be billed to and shall be reimbursed by the Division through the pharmacy program (refer to OAR chapter 410, division 121, Pharmaceutical Services) or at the All-Inclusive Rate (AIR) as established annually by the Indian Health Service (IHS); and.¶

(c) Targeted ~~Case~~ ~~Management~~ (TCM) services. For specific information, refer to OAR chapter 410, division 138, TCM.¶

(12) ~~Client~~ Member contact with more than one health professional for the same diagnosis or multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. For exceptions to this rule, see OAR 410-146-0086 for reporting multiple encounters.¶

(13) For claims that require a procedure and ~~diagnosis~~ ~~code~~, the ~~Provider~~ must bill as instructed in the appropriate Division program rules and must use the appropriate HIPAA procedure Code Set established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided (refer to OARs 410-120-1280, Billing and OAR 410-146-0040, ICD-10-CM Diagnosis Codes and CPT/HCPCS Procedure Codes).¶

(14) Services furnished by AI/AN enrolled ~~Providers~~ that may meet the criteria of a valid encounter (refer to individual program administrative rules for service limitations):.¶

(a) Medical (OAR chapter 410, division 130);.¶

(b) The Division covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line, even if the treatments for that condition are not covered under the State Plan or do not pair with that condition on the HERC's OHA Prioritized List of Health Services. Once a diagnosis is established for a service, treatment, or item that falls below the funding line, the Division may ~~not~~ cover any other State Plan services related to the diagnosis; that do not pair with the condition on the OHA Prioritized List.¶

(c) Tobacco Cessation (OAR 410-130-0190);.¶

(d) Dental (OAR 410-146-0380 and OAR chapter 410, division 123);.¶

(e) Vision (OAR chapter 410, division 140);.¶

(f) Physical Therapy (OAR chapter 410, division 131);.¶

(g) Occupational Therapy (OAR chapter 410, division 131);.¶

(h) Podiatry (OAR chapter 410, division 130);.¶

(i) Behavioral ~~Health~~ OAR chapter 309;.¶

(j) Substance Use Disorder services (OAR 410-146-0021) require a letter or licensure of approval by the Division;.¶

(k) Maternity Case Management (OAR 410-146-0120);.¶

~~(L)~~ Speech (OAR 410 Division 129);.¶

(m) Hearing (OAR 410 Division 129);.¶

(n) The Division considers a home visit for assessment, diagnosis, treatment, or ~~Maternity~~ ~~Case~~ ~~Management~~ (MCM) as an encounter. The Division does not consider home visits for MCM as ~~Home~~ ~~Health~~ ~~Services~~.¶

(o) Professional services provided in a ~~Hospital~~ setting;.¶

(p) Prescriptions dispensed by an IHS or Tribal 638 Pharmacy constitute a separate encounter reimbursed at the annually published IHS All-Inclusive-Rate;.¶

(q) Other Title XIX or XXI services as allowed under Oregon's Medicaid and CHIP State Plan Amendments, Oregon's approved 1115 Medicaid Demonstration, and the Division's administrative rules.¶

(15) The following ~~Practitioners~~ are recognized by the Division:.¶

(a) Doctors of medicine, osteopathy, and naturopathy;.¶

(b) Licensed ~~Physician~~ ~~Associates~~.¶

(c) Nurse ~~Practitioners~~.¶

(d) Registered nurses may accept and implement orders within the scope of their license for ~~client~~ Member care and treatment under the supervision of a licensed health care professional recognized by the Division in this section and who is authorized to independently diagnose and treat according to appropriate State of Oregon's Board of Nursing OARs;.¶

(e) Nurse midwives;¶

(f) Dentists;¶

(g) Dental hygienists who hold a Limited Access Permit (LAP) may provide dental hygiene services without the supervision of a dentist in certain settings. For more information, refer to the section on Limited Access Permits in ORS 680.200 and the appropriate Oregon Board of Dentistry OARs;¶

(h) Pharmacists;¶

(i) Psychiatrists;¶

(j) Licensed Clinical Social Workers;¶

(k) Clinical psychologists;¶

(~~l~~) Acupuncturists, refer to OAR chapter 410, division 130 for service coverage and limitations;¶

(m) Licensed professional counselor;¶

(n) Licensed marriage and family therapist; and¶

(o) Other health care professionals providing services within their scope of practice and working under the supervision requirements of:¶

(A) Their individual provider certification or license; or¶

(B) A clinic's behavioral health certification or SUD program approval or licensure by the Division.¶

(16) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies, including drugs and biologicals, furnished on a part-time or intermittent basis to home-bound AI/AN ~~client~~ Members residing on tribal land and any other ambulatory services covered by the Division are also reimbursable as permitted within the clinic's scope of services.¶

(17) The Division shall reimburse the following services on a fee-for-service basis outside of the IHS all-inclusive encounter rate and according to the ~~p~~Physician fee schedule:¶

(a) Laboratory and radiology services;¶

(b) Contraception supplies and medications;¶

(c) Administrative medical examinations and report services (refer to OAR chapter 410, division 150);¶

(d) Death with Dignity services (refer to OAR 410-130-0670); and¶

(e) Comprehensive environmental lead investigation (refer to OAR 410-130-0245, Early and Periodic Screening, Diagnostic and Treatment program).¶

(18) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before billing the Division (refer to OAR 410-120-1140, Verification of Eligibility).¶

(19) When a ~~p~~Provider receives a payment from any source prior to the submission of a claim to the Division, the amount of the payment must be shown as a credit on the claim in the appropriate field (refer to OARs 410-120-1280, Billing and 410-120-1340, Payment).

Statutory/Other Authority: ORS 413.042, ORS 414.065

Statutes/Other Implemented: ORS 414.065

AMEND: 410-146-0220

RULE SUMMARY: Remove reference to a "comfort care" line on the Prioritized List that no longer exists. Capitalize defined terms.

CHANGES TO RULE:

410-146-0220

Death With Dignity ¶

(1) Death with Dignity is a Covered Service, except for those facilities limited by the Assisted Suicide Funding Restriction Act of 1997 (ASFRA), ~~and is incorporated in the "comfort care" condition/treatment line on the HERC's Prioritized List of Health Services.~~ ¶

(2) All ~~D~~death with ~~D~~dignity services must be billed directly to the Division, ~~even if the client is in a prepaid health plan.~~ Death with ~~D~~dignity services are not part of the AI/AN encounter rate. ¶

(3) Follow criteria outlined in OAR 410-130-0670.

Statutory/Other Authority: ORS 413.042, ORS 414.065

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-146-0470

Traditional Health Care Practices

(1) Definitions:¶¶

(a) Indian Health Care Provider (IHCP) means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).¶¶

(b) Medicaid Management Information System (MMIS) means the automated claims processing and information retrieval system for handling all Medicaid transactions. The objectives of the system include verifying provider enrollment and client eligibility, managing health care provider claims and benefit package maintenance, and addressing a variety of Medicaid business needs.¶¶

(c) National Provider Identifier means a unique 10-digit number that is issued by the Centers for Medicare and Medicaid and is used to identify health care providers throughout the health care industry.¶¶

(d) Prospective Payment System means the method of reimbursement in which payment is made based on a pre-determined, fixed amount.¶¶

(e) IHCP Prospective Payment Rates (PPS) means payments made to an IHCP that is based on a clinic-specific, cost-based rate, calculated according to each IHCP's reported costs and volume of patient encounters.¶¶

(f) Tribal-Based Practices means those practices that are based on cultural principles that have been traditionally used in tribal communities since time immemorial. Tribal-Based Practices are culturally validated utilizing the process that has been established and been approved by the review panel of tribal representatives. Not all Tribal-based practices are eligible for Medicaid reimbursement.¶¶

(g) Traditional Health Care Practices means those Tribal-based practices that have been determined to be eligible for Medicaid reimbursement.¶¶

(h) Tribal Based Practices Review Panel means the panel comprised of tribal representatives who have been elected by representatives from the Nine Federally Recognized Tribes of Oregon. The Tribal Based Practices Review Panel is responsible for accepting, reviewing, and approving Tribal based practices that have been proposed and submitted to the Tribal Based Practices Review Panel for review and approval when evidence, based on research, practice, and culture-based knowledge, shows the Tribal-based practice to be effective. The Tribal Based Practices Review Panel may also provide technical assistance on an ongoing basis to the Tribes and Tribal Organizations regarding Tribal Based Practices. The panel meets on an as-needed basis. Review panel membership is determined by tribal representatives from the Nine Federally Recognized Tribes of Oregon.¶¶

(i) Traditional Knowledge Keeper(s) means the individual(s) responsible for providing the Tribal Based Practices. Traditional Knowledge Keepers have gained the traditional knowledge according to their Tribal community that is necessary to implement Tribal Based Practices in a meaningful, respectful, and purposeful way. Examples of Traditional Knowledge Keepers may include elders, cultural or spiritual advisors, traditional foods providers, medicines gatherers, sweat lodge leaders, Tribal singers, dancers, artists, and more. These individuals must meet the qualifications in Section (5) of this rule and are authorized to provide Tribal Based Practices as an employee or contractor of an IHCP.¶¶

(j) Urban Indian Health Program (UIHP) means an urban Indian organization as defined in section 1603 of Title 25 that has an IHS Title V contract as described in Section 1653 of Title 25.¶¶

(2) Eligibility to Receive Tribal-Based Practices: To be eligible to receive one or more Tribal-Based Practice(s), an individual must meet the following criteria:¶¶

(a) Is enrolled in Medicaid or CHIP; and,¶¶

(b) Is able to receive services delivered by an Indian Health Care Provider (IHCP), as determined by the IHCP.¶¶

(3) Delivery of Traditional Health Care Practices to Qualifying Individuals¶¶

(a) The IHCP shall provide Traditional Health Care Practices to qualifying Medicaid or CHIP Members through employed or contracted Traditional Knowledge Keepers.¶¶

(b) The Tribal Based Practices Review Panel shall review and maintain a list of available Tribal-Based Practices and the scope of each service. This list will identify the Tribal-Based Practices that are also approved as Traditional Health Care Practices and covered by Medicaid.¶¶

(c) The IHCP shall determine the list and scope of each Traditional Health Care Practices that will be offered to qualifying Medicaid and CHIP Members at each IHCP.¶¶

(d) Traditional Health Care Practices shall not be subject to ~~OHP's~~ the OHA Prioritized List of Health Services as described in OAR 410-141-3830.¶¶

- (e) The IHCP shall maintain internal supporting documentation relating to the provision of the service for the OHP enrolled Member in accordance with OAR 410-120-1360.-¶¶
- (4) Reimbursement for the Delivery of Tribal Based Practices.-¶¶
- (a) The IHCP shall be permitted to seek Medicaid reimbursement for expenditures on any Traditional Health Care Practice following the requirements outlined in this section.-¶¶
- (b) The IHCP shall ensure that all Medicaid claims, even those claims that are for Traditional Health Care Practices provided to OHP Members enrolled in Coordinated Care Organizations (CCOs), are submitted to the Authority directly with the applicable information that identifies the IHCP as the Billing Provider, and the Traditional Knowledge Keeper identified as the Rendering Provider. The IHCP shall not submit Medicaid claims relating to the provision of Traditional Health Care Practices to CCOs.-¶¶
- (c) The IHCP shall ensure that diagnosis code Z7689 and procedure code H0051 are used for the reimbursement of all Tribal-Based Practices claims.-¶¶
- (d) The Authority shall process all Traditional Health Care Practices claims at the IHCP's chosen specified encounter rate (Indian Health Service (IHS) or Prospective Payment System Rates (PPS)).-¶¶
- (e) The Authority shall not provide Traditional Health Care Practice reimbursement for the following items or services:-¶¶
- (A) Construction costs (including building modification and building rehabilitation);-¶¶
 - (B) Room and board;-¶¶
 - (C) Capital investments; and¶¶
 - (D) Research grants and expenditures not related to monitoring and evaluation.¶¶
- (f) Payment for permissible claims submitted for the provision of Traditional Health Care Practices shall be contingent on the availability of federal funding.-¶¶
- (5) Provider Qualifications for Traditional Knowledge Keepers-¶¶
- (a) The IHCP shall be responsible for confirming that all contracted and employed Traditional Knowledge Keepers meet the qualifications described in this Section 5.-¶¶
- (b) In order to receive OHP reimbursement for the provision of Traditional Health Care Practices, a Traditional Knowledge Keeper must be, at the time the practice was performed:-¶¶
- (A) Be employed or contracted with an IHCP.¶¶
 - (B) Meet Traditional Knowledge Keeper qualifications, as determined by the IHCP.-¶¶
 - (C) Have the necessary experience and appropriate training to serve as a Traditional Knowledge Keeper, as determined by the IHCP.-¶¶
- (c) Each IHCP shall ensure the following for all the delivery of Tribal-Based Practices:-¶¶
- (A) Establish methods for determining whether its employees or contractors are qualified to serve as Traditional Knowledge Keepers.-¶¶
 - (B) Bill the Authority for Traditional Health Care Practices furnished only by Traditional Knowledge Keepers who are qualified to provide them, as determined by the IHCP.-¶¶
 - (d) Each IHCP shall send the Authority a list of employed or contracted Traditional Knowledge Keepers, which must be updated as changes occur. Each IHCP must provide the Authority with copies of any updated list as they occur.¶¶
 - (e) Each Traditional Knowledge Keeper on the list described in (5)(d) shall enroll with Oregon Health Plan (OHP) Open Card by submitting the necessary provider forms to OHA.-¶¶
 - (A) An IHCP shall not submit any claim for payment for the provision of any Traditional Health Care Practice by a Traditional Knowledge Keeper if such Traditional Knowledge Keeper was not enrolled with the Authority as required under this subsection at the time the practice was performed.-¶¶
 - (B) Traditional Knowledge Keepers shall not be required to have a National Provider Identifier (NPI) number.-¶¶
 - (f) The Authority shall verify that the Traditional Knowledge Keeper is on the list provided by each IHCP, as described in (5)(d) of this rule-¶¶
 - (g) Once verified, the Authority shall enroll the Traditional Knowledge Keeper in Medicaid Management Information System (MMIS).
- Statutory/Other Authority: 25 U.S.C. § 1603
- Statutes/Other Implemented: 25 U.S.C. § 1603

AMEND: 410-147-0000

RULE SUMMARY: Update OAR reference to OAR 410-141-3830. Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-147-0000

Foreword ¶

(1) The Division of Medical Assistance Programs" (Division) Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules are designed to assist FQHCs and RHCs to deliver health care services and prepare health claims for clients with Medical Assistance Program coverage.¶

(2) The FQHC and RHC rules contain important information including general program policy, provider enrollment, and maintenance of financial records, special programs, and billing information.¶

(3) It is the clinic's responsibility to understand and follow all Division rules that are in effect on the date services are provided.¶

(4) Typically rules are modified twice a year, April for technical changes and October for technical and/or program changes. Technical changes refer to operational information. All provider rules can be found on the Division website.¶

(5) FQHCs and RHCs must use rules contained in the FQHC and RHC rules. Do not use other provider rules unless specifically directed in rules contained in the FQHC and RHC rules. Division General Rules and the Oregon Health Plan (OHP) Administrative Rules are intended to be used in conjunction with all program rules including the FQHC and RHC provider rules.¶

(6) The ~~Health Services Commission's~~ OHA Prioritized List of Health Services is found in the ~~OHP Administrative Rules (OAR 410-141-0520)~~ 3830 and defines the services covered under the Division.¶

(7) An FQHC is defined as a clinic that is recognized and certified by the Centers for Medicare and Medicaid Services (CMS) as meeting federal requirements as an FQHC.¶

(8) An RHC is defined as a clinic that is recognized and certified by CMS as meeting federal requirements for payment for RHC services.

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0020

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-147-0020

Professional Ambulatory Services ¶

(1) Providers must use the following rules in conjunction with all individual program rules to determine service coverage and limitations for Oregon Health Plan (OHP) clients according to their benefit packages: Medical, EPSDT, Diagnostic, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Chemical Dependency, Maternity Case Management, Speech, Hearing, and Home Health services are governed by the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules (OAR 410 division 147), General Rules (410 division 120), OHP Administrative Rules (410-141-0480, 410-141-0500, and 410-141-0520), and the ~~Health Services Commission's (HSC)~~OHA Prioritized List of Health Services (OHA Prioritized List), and the Oregon Health Authority (Authority) rules related to provider enrollment and claiming (943-120-0300 through 0380).¶

(2) Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are eligible for reimbursement of covered professional services provided within the scope of the clinic and within the individual practitioner's scope of license or certification. See also OAR 410-147-0120(6). For the purposes of this rule, a clinic's "scope" refers to authorization or certification to provide services if required.¶

(a) For FQHCs only, services must be provided in accordance with the FQHC's scope as approved by the Health Resources and Services Administration (HRSA) Notice of Grant Award Authorization; and¶

(b) Both FQHCs and RHCs must provide services within the scope of the Addictions and Mental Health Division (AMH) certification for the facility, if required. See OAR 410-147-0320(3) and (5).¶

(3) The date of service determines the appropriate version of the FQHC and RHC rules, General Rules, and ~~HSC~~OHA Prioritized List to determine coverage.

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Remove reference to nonfunded region of the Prioritized List. Update reference to the OHA Prioritized List. Replace references to a "client" with "Member." Capitalize defined terms.

CHANGES TO RULE:

410-147-0120

Division Encounter and Recognized Practitioners ¶

- (1) The Division of Medical Assistance Programs (Division) reimburses Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services according to the Prospective Payment System (PPS) as follows: ¶
- (a) When the service(s) meet the criteria of a valid encounter as defined in Sections (2) through (4) of this rule: ¶
- (b) Reimbursement is limited to the Division's Medicaid-covered services according to a client Member's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act. Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act are not reimbursed by the Division. ¶
- (2) For the provision of services defined in Titles XIX and XXI and provided through an FQHC or RHC, an "encounter" is defined as a face-to-face or telephone contact between a health care professional and an eligible OHP client Member within a 24-hour period ending at midnight, as documented in the client Member's medical record. Section (4) of this rule outlines limitations for telephone contacts that qualify as encounters. For purposes of this rule, a face-to-face "encounter" includes services provided via a synchronous two-way audiovisual link between a patient and a provider per OAR 410-130-0610. ¶
- (3) An encounter includes all services, items and supplies provided to a client Member during the course of an office visit, except as excluded in Sections (6) and (12) of this rule, and those services considered "incident-to." These services are inclusive of the visit with the core provider meeting the criteria a valid encounter and reimbursed at the PPS all-inclusive encounter rate. These services include: ¶
- (a) Drugs or medication treatments provided during a clinic visit are inclusive of the encounter, with the exception of contraception supplies and medications as costs for these items are excluded from the PPS encounter rate calculation (see OAR 410-147-0280 Drugs and OAR 410-147-0480 Cost Statement (DMAP 3027) Instructions); ¶
- (b) Medical supplies, equipment, or other disposable products (e.g. gauze, band-aids, wrist brace) are inclusive of an office visit; ¶
- (c) Laboratory and/or radiology services, or both (even if performed on another day); ¶
- (d) Venipuncture for lab tests. The Division does not deem a visit for lab test only to be a clinic encounter; ¶
- (4) Telephone encounters qualify as a valid encounter for services provided in accordance with OAR 410-130-0595, Maternity Case Management (MCM) and 410-130-0190, Tobacco Cessation (see also OAR 410-120-1200). Except as set forth below, providers may not make telephone contacts at the exclusion of face-to-face visits. ¶
- (a) Telephone encounters must include all the same components of the service as if provided face-to-face. ¶
- (b) During a state of emergency of an epidemic outbreak of an infectious disease impacting the safety of public health, in accordance with the Health Evidence Review Commission's OHA Prioritized List, guideline notes, and OAR 410-130-0610 (for dates of service on or before December 31, 2020) and OAR 410-120-1990 (for dates of service on or after January 1, 2021), telephonic evaluation management services, assessment and management services, and psychotherapy are appropriate to ensure access to care while avoiding and preventing unnecessary potential infectious exposure, and may be made in place of a face-to-face visit. ¶
- (5) Extended care services furnished under a contract between a county Community Mental Health Program (CMHP) of the FQHC and Addictions and Mental Health Division (AMH) are reimbursed outside of the PPS. Extended care services are those services provided under AMH's licensure requirements and reimbursed under AMH's terms and conditions. ¶
- (6) Some Division Medicaid-covered services are not reimbursable when furnished according to Oregon Health Plan (OHP) client Member's benefit package as a stand alone service. Although costs incurred for furnishing these services are inclusive of the PPS all-inclusive rate calculation, visits where these services were furnished as a stand-alone service were excluded from the denominator for the PPS rate calculation (see OAR 410-147-0480, Cost Statement (DMAP 3027) Instructions). The following services when furnished as a stand-alone service are not reimbursable: ¶
- (a) Sign language and oral interpreter services; ¶
- (b) Supportive rehabilitation services including, but not limited to, environmental intervention, supported housing and employment, or skills training and activity therapy to promote community integration and job. ¶
- (7) FQHCs and RHCs may provide certain services, items and supplies that are prohibited from being billed under the health centers provider enrollment, and requires separate enrollment (see OAR 410-147-0320(1)(b) Federally

Qualified Health Center (FQHC)/Rural Health Clinics (RHC) Enrollment). These services include:¶

- (a) Durable ~~m~~Medical ~~e~~Equipment, ~~p~~Prosthetics, ~~e~~Orthotics or medical supplies (DMEPOS) (e.g. diabetic supplies) not generally provided during the course of a clinic visit (refer to OAR chapter 410, division 122, DMEPOS);¶
- (b) Prescription pharmaceutical ~~and/or~~ biologicals not generally provided during the clinic visit must be billed to ~~DMA~~the Authority through the pharmacy program (refer to OAR chapter 410, division 121, Pharmaceutical Services);¶
- (c) Targeted ~~e~~Case ~~m~~Management (TCM) services (refer to OAR chapter 410, division 138).¶

(8) ~~Client~~Member contact with more than one health professional for the same diagnosis or multiple encounters with the same health professional that take place on the same day and at a single location constitute a single encounter. For exceptions to this rule, see OAR 410-147-0140 for reporting multiple encounters.¶

(9) Providers are advised to include all services that can appropriately be reported using a procedure code on the claim and bill as instructed in the appropriate Division program rules and must use the appropriate HIPAA procedure code set such as CPT, HCPCS, ICD-10-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided. For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the ~~client~~Member's condition and the service(s) provided. Providers must use the ICD-10-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual ~~p~~Provider rules (refer to OAR 410-120-1280 Billing and see OAR 410-147-0040 ICD-10-CM Diagnosis and CPT/HCPCS Procedure Codes).¶

(10) FQHC and RHC services that may meet the criteria of a valid encounter are (refer to individual program administrative rules for service limitations.):¶

- (a) Medical (OAR chapter 410, division 130);¶
- (b) Diagnostic: The Division covers reasonable services for diagnosing conditions, including ~~the initial diagnosis of a condition that is below the funding line on the Prioritized List of Health Services. Once a diagnosis is established for a service, treatment or item that falls below the funding line, the Division will not cover any other services related to the diagnosis; or for which further treatments may not be covered.~~¶
- (c) Tobacco Cessation (OAR 410-130-0190);¶
- (d) Dental (see to OAR 410-147-0125, and refer to OAR chapter 410, division 123);¶
- (e) Vision (OAR chapter 410, division 140);¶
- (f) Physical Therapy (OAR chapter 410, division 131);¶
- (g) Occupational Therapy (OAR chapter 410, division 131);¶
- (h) Podiatry (OAR chapter 410, division 130);¶
- (i) ~~Ment~~Behavioral Health (Refer to the ~~Division of Addiction and Mental Health (AMH)~~Behavioral Health Division (BHD) for appropriate OARs);¶
- (j) Alcohol, Chemical Dependency, and Addiction services (see also OAR 410-147-0320). Requires a letter or licensure of approval by ~~AMH~~BHD (refer to ~~AMH~~BHD for appropriate OARs);¶
- (k) Maternity Case Management (MCM) (OAR 410-147-0200);¶
- (~~L~~) Speech (OAR chapter 410, division 129);¶
- (m) Hearing (OAR chapter 410, division 129);¶
- (n) The Division considers a home visit for assessment, diagnosis, treatment or MCM as an encounter. The Division does not consider home visits for MCM as ~~H~~Home H~~ealth s~~ervices;¶
- (o) Professional services provided in a ~~h~~Hospital setting; and¶

¶

- (p) Other Title XIX or XXI services as allowed under Oregon's Medicaid and CHIP State Plan Amendments and the Division's administrative rules.¶

(11) The following ~~p~~Practitioners are recognized by the Division:¶

- (a) Doctors of medicine, osteopathy and naturopathy;¶
- (b) Licensed Physician Associates;¶
- (c) Dentists;¶
- (d) Dental Hygienists who hold a Limited Access Permit (LAP) - may provide dental hygiene services without the supervision of a dentist in certain settings. For more information, refer to the section on Limited Access Permits, ORS 680.200 and the appropriate Oregon Board of Dentistry OARs;¶
- (e) Pharmacists;¶
- (f) Nurse Practitioners;¶
- (g) Nurse ~~M~~idwives;¶
- (h) Other specialized ~~n~~Nurse pPractitioners;¶
- (i) Registered nurses - may accept and implement orders within the scope of their license for ~~client~~Member care and treatment under the supervision of a licensed health care professional recognized by the Division in this section and who is authorized to independently diagnose and treat according to appropriate State of Oregon's

Board of Nursing OARs;¶

(j) Psychiatrists;¶

(k) Licensed Clinical Social Workers;¶

(~~l~~) Clinical psychologists;¶

(m) Acupuncturists - Refer to OAR chapter 410, division 130 for service coverage and limitations;¶

(n) Licensed professional counselor;¶

(o) Licensed marriage and family therapist; or¶

(p) Other health care professionals providing services within their scope of practice and working under the supervision requirements of;¶

(A) Their individual ~~p~~Provider's certification or license; or¶

(B) A clinic's mental health certification or alcohol and other drug program approval or licensure by the ~~Addictions and Mental Behavioral Health Division (AMHBHD)~~ (see OAR 410-147-0320).¶

(12) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to ~~home-bound clients~~ Members unable to leave their home (limited to areas in which the Secretary of Health and Human Services has determined that there is a shortage of ~~Home Health Agencies~~ - Code of Federal Regulations 42 ~~§~~ 405.2417), and any other ambulatory services covered by the Division are also reimbursable as permitted within the clinic's scope of services (see OAR 410-147-0020).¶

(13) FQHCs and RHCs may furnish services that are reimbursed outside of the PPS all-inclusive encounter rate and according to the ~~p~~Physician fee schedule. These services include:¶

(a) Administrative medical examinations and report services (refer to OAR chapter 410, division 150);¶

(b) Death with Dignity services (refer to OAR 410-130-0670);¶

(c) Services provided to Citizenship Waived Medical (CWM) ~~client~~ Members (refer to OARs 410-120-1210, 461-135-1070 and 410-130-0240);¶

(d) Services provided to Qualified Medicare Beneficiary (QMB) only ~~client~~ Members (refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System). Specific billing information is located in the FQHC and RHC Supplemental Information billing guide; and¶

(e) Comprehensive environmental lead investigation (refer to OAR 410-130-0245, Early and Periodic Screening, Diagnostic and Treatment Program).¶

(14) OHP ~~b~~Benefit ~~p~~Package and delivery system are described in OAR 410-120-1210. Most ~~OHP client~~ Members have prepaid health services, contracted for by the Authority through enrollment in a ~~Prepaid Health Plan (PHP)~~. ~~Non-PHP-enrolled clients~~, Coordinated Care Organization (CCO). Open Card Members are not enrolled in a CCO and receive services on an "open card" or "fee-for-service" (FFS) basis.¶

(a) The Division is responsible for making payment for services provided to ~~e~~Open ~~e~~Card ~~client~~ Members. The ~~p~~Provider will bill the Division the clinic's encounter rate for Medicaid-~~e~~Covered ~~s~~Services provided to ~~these client~~ Open Card Members according to their OHP ~~b~~Benefit ~~p~~Package (see OAR 410-147-0360, Encounter Rate Determination).¶

(b) A ~~PHP~~ CCO is responsible to provide, arrange and make reimbursement arrangements for ~~e~~Covered ~~s~~Services for their ~~Division m~~ CCO Members (refer to OAR 410-120-0250, and OAR chapter 410, division 141, OHP administrative rules governing ~~PHP~~ CCOs). The ~~p~~Provider must bill the ~~PHP~~ CCO directly for services provided to an enrolled ~~client~~ CCO Member (See also OARs 410-147-0080, Prepaid Health Plans, and 410-147-0460, PHP Supplemental Payment). Clinics must not bill the Division for ~~PHP~~ CCO-covered services provided to eligible ~~OHP clients enrolled in PHP~~ CCO Members. Exceptions include:¶

(A) Family ~~p~~Planning ~~s~~Services provided to a ~~PHP-enrolled client~~ CCO Member when the clinic does not have a contract with the ~~PHP~~ CCO, and if the ~~PHP~~ CCO denies payment (see OAR 410-147-0060); and¶

(B) HIV/AIDS prevention provided to a ~~PHP-enrolled client~~ CCO Member when the clinic does not have a contract with the ~~PHP~~ CCO, and if the ~~PHP~~ CCO denies payment (see OAR 410-147-0060).¶

(15) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Division will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before billing the Division (refer to OAR 410-120-1140 Verification of Eligibility).¶

(16) When a ~~p~~Provider receives a payment from any source prior to the submission of a claim to the Division, the amount of the payment must be shown as a credit on the claim in the appropriate field (refer to OARs 410-120-1280 Billing and 410-120-1340 Payment).

Statutory/Other Authority: ORS 413.042, ORS 414.065

Statutes/Other Implemented: ORS 414.065

AMEND: 410-147-0260

RULE SUMMARY: Remove reference to a “comfort care” line on the Prioritized List that no longer exists.

CHANGES TO RULE:

410-147-0260

Death With Dignity ¶

~~[Reserved]~~ (1) Death With Dignity is a covered service, except for those facilities limited by the Assisted Suicide Funding Restriction Act of 1997 (ASFRA).¶

(2) All claims for Death With Dignity services must be billed directly to the Division of Medical Assistance Programs (Division), even if the client is in a managed care plan. Death With Dignity services are not part of the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) encounter rate.¶

(3) Follow criteria outlined in OAR 410-130-0670.

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Remove reference to nonfunded region of the Prioritized List. Update reference to the OHA Prioritized List. Replace references to a "client" with "Member." Capitalize defined terms.

CHANGES TO RULE:

410-147-0500

Total Encounters for Cost Reports ¶

(1) Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHCs) are required to report the total number of encounters for furnishing services outlined in 42 USC 1396d(a)(2)(C) and 1396d(a)(2)(B), respectively. ¶

(2) In general, the Division of Medical Assistance Programs (DMAP) calculates a FQHC or RHC's Prospective Payment System (PPS) encounter rate by dividing the total costs incurred by a clinic for furnishing services as defined in 42 USC 1396d(a)(2)(B) or (C) by the total number of all clinic visits, or "encounters." The intent of PPS is to calculate the average cost of an encounter, and not the average cost of a Medicaid billable encounter. ¶

(3) This rule provides guidance for cost reporting of all encounters. It is the responsibility of the FQHC and RHC to report all encounters, except when expressly directed not to elsewhere in this rule. FQHCs and RHCs are required to include ~~ALL~~ the following: ¶

(a) Encounters for all ~~client~~Members regardless of payor; ¶

(b) Encounters for FQHC or RHC services that are not covered by Medicaid, Medicare, Third Party Payor or other party, but otherwise have an associated cost for providing the service whether billed to the ~~client~~Member (e.g. uninsured, signed waiver on file) or absorbed by the clinic; and; ¶

(c) Encounters ~~regardless of line placement on the Health Evidence Review Commission's (HERC) for Condition/Treatment Pairs not appearing on the OHA~~ Prioritized List of Health Services. For the purpose of reporting encounters according to this rule, encounters are not subject to the ~~HERC~~OHA Prioritized List, or service limitations and benefit reductions implemented by the Division of Medical Assistance Programs (DMAP). ¶

(4) FQHCs and RHCs must report all encounters furnished to all ~~client~~Member populations irrespective of coverage or payor source. Examples of ~~client~~Member populations include, but are not limited to: ¶

(a) Oregon Health Plan (OHP) ~~client~~Members (includes both ~~fee for service and prepaid health plan (PHP)~~ ~~client~~Open Card Members and CCO Members). Refer to OAR 410-147-0120 for more information regarding OHP encounters; ¶

(b) Citizenship Waived Medical (CWM) ~~client~~Members. Refer also to OAR ~~410-120-1210(3)(f)~~ chapter 410, division 134. ¶

(c) Family Planning Expansion Program (FPEP) Title X, clients; ¶

(d) Uninsured ~~and/or~~ self-pay clients; ¶

(e) Medicare clients; ¶

(f) Third-~~p~~ Party or private pay insurance clients; ¶

(g) County- ~~and/or~~ clinic-pay clients (services paid or funded by the county or clinic); and ¶

(h) Clients funded by federal, state, local or other grants. ¶

(5) FQHCs and RHCs must exclude from the total number of reported encounters: ¶

(a) Encounters attributed to non-allowable costs: ¶

(A) Services performed under the auspices of a Women, Infant and Children (WIC) program or a WIC contract; ¶

(B) Services performed and reimbursed under separate enrollment (e.g., Targeted Case Management); ¶

(C) Services provided by patient advocates/ombudsmen and Outstationed Outreach Workers, employed by or under contract with the FQHC or RHC, for the primary purpose of providing outreach ~~and/or~~ group education sessions; ¶

(D) Provider participation in a community meeting or group session that is not designed to provide clinical services. This includes, and is not limited to, information sessions for prospective Medicaid beneficiaries, and information presentations about available health services at the FQHC or RHC; and ¶

(E) Health services provided as part of a large-scale "free to the public" or "nominal fee" effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair); ¶

(b) Encounters for specific services outlined in 42 USC 1396d(a)(2)(B) and (C), that do not meet the criteria of a valid encounter when furnished as a stand-alone service. Costs for furnishing these services is an allowed administrative program cost and should be reported on a clinic's cost statement for calculating a clinic's PPS encounter rate. Refer to OAR 410-147-0480, Costs Statement (DMAP 3027) Instructions. Examples include, but are not limited to: ¶

(A) Case management services for coordinating health care for a ~~client~~Member; ¶

(B) Enabling services, including but not limited to, sign language and oral interpreter services; ¶

(C) Supportive, rehabilitation services including, but not limited to, environmental intervention, and supported housing and employment; skills training and activity therapy to promote community integration and job readiness; ¶

(D) Laboratory and radiology services, including venipuncture and tuberculosis (TB) tests (the initial visit for the TB test administered to the epidermis); ¶

(E) Prescription refills; and ¶

(F) Services provided without the ~~client~~Member present, except for telephone contacts as specified in this rule section (6)(c). ¶

(6) FQHCs and RHCs are required to include encounters for services furnished by ~~p~~Practitioners recognized by ~~DMAP~~ in OAR 410-147-0120(6). Examples of encounters that may be overlooked but should be included are: ¶

(a) Encounters ~~below the funding line on the Health Services Commission's Prioritized List of Health Services. All encounters are to be reported regardless of line placement; for Condition/Treatment Pairs not appearing on the OHA Prioritized List of Health Services.~~ ¶

(b) Encounters outside of the clinic by primary care ~~p~~Practitioners (e.g. services furnished in a ~~h~~Hospital or residential treatment setting); ¶

(c) Telephone contacts as provided for in the Tobacco Cessation, OAR 410-130-0190; and Maternity Case Management (MCM), 410-130-0595, programs. See also 410-120-1200(2)(y); ¶

(d) Medication management-only encounters by a ~~b~~Behavioral ~~h~~Health ~~p~~Practitioner; ¶

(e) Encounters by Registered and Licensed Practical Nurses; ¶

(A) Home encounters in an area in which the Secretary of the Health Resources and Services Administration, Health and Human Services, has determined that there is a shortage of ~~h~~Home ~~h~~Health ~~a~~Agencies (OAR 410-147-0120(10)); ¶

(B) Administration of immunizations/vaccinations encounters; ¶

(C) "99211" encounters; and ¶

(D) Maternity Case Management (MCM) encounters. ¶

(7) Global procedures require attention for accurate reporting of encounters: ¶

(a) Obstetrics procedures: Each antepartum, delivery and postpartum encounter included in a global procedure for maternity and delivery services should be reported as a separate encounter; ¶

(b) Dental procedures: Multiple contacts for global dental procedures should be reported as a single encounter. Refer to OAR 410-147-0040(5) ICD-10-CM Diagnosis and CPT/HCPCs Procedure Codes, for more information; ¶

(c) Surgical procedures: Refer to OAR 410-147-0040(5), ICD-10-CM Diagnosis and CPT/HCPCs Procedure Codes, for more information: ¶

(A) Services within a surgical package and "included" in a given CPT surgical code are reported as a single encounter. Refer to OAR 410-130-0380, Surgical Guidelines, for more information; and ¶

(B) The initial consultation or evaluation of the problem by the ~~p~~Provider to determine the need for surgery, and separate from a preoperative appointment, is a separate encounter. ¶

(8) A surgical procedure furnished to an ~~OHP client~~Member and provided by more than one surgeon employed by the FQHC or RHC does not count as multiple encounters. The exception to this rule is major surgery, including a cesarean delivery, furnished to a CWM ~~client~~Member. Services provided by the primary surgeon and the assistant surgeon, when both are employed with the FQHC or RHC, may be eligible as multiple encounters if ~~m~~Medically ~~n~~Necessary. ¶

(9) When two ~~(2)~~(5) or more services are provided on the same ~~d~~Date of ~~s~~Service: ¶

(a) With distinctly different diagnoses, a clinic should report multiple encounters when the criteria in OAR 410-147-0140, Multiple Encounters, is met; or ¶

(b) With similar diagnoses, a clinic must report one encounter. ¶

(10) Clinics must maintain, for no less than five ~~(5)~~(5) years, all documentation relied upon by the clinic to calculate the number of encounters reported on the cost statement (DMAP 3027): ¶

(a) All documentation supporting the number of encounters reported on the cost statement must be sufficient to withstand an audit; and ¶

(b) The total number of encounters calculated from all sources of documentation must reconcile to the total number of encounters reported on the cost statement, and subtotaled encounters must reconcile to each documentation source relied upon.

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.065

AMEND: 410-148-0000

RULE SUMMARY: Update reference to the OHA Prioritized List. Capitalize defined terms.

CHANGES TO RULE:

410-148-0000

Foreword ¶

(1) The Home Enteral/Parenteral Nutrition and IV Services rules are a user's manual designed to assist providers in preparing health claims for medical assistance program clients. The Home Enteral/Parenteral Nutrition and IV Services ~~p~~Provider rules are to be used in conjunction with the ~~G~~general ~~R~~Rules for Oregon Medical Assistance Programs, the Oregon Health Plan administrative rules, the Pharmaceutical Services administrative rules, the Early and Periodic Screening, Diagnostic and Treatment administrative rules, and other relevant provider rules and supplemental information. ¶

(2) The Home Enteral/Parenteral Nutrition and IV Services provider rules include procedure codes with restrictions, and limitations. The Home EPIV code and fee schedule, which is not a part of these rules, is not an exhaustive list of OHP covered service codes. Please consult the OHA Prioritized List of Health Services for the Oregon Health Plan and the Division's Maximum Allowable Table. ¶

(3) The Division endeavors to furnish medical ~~p~~Providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements. ¶

(4) Providers should always follow the Division administrative rules in effect on the ~~d~~Date of ~~s~~Service. ¶

[Publications: Publications referenced are available from the agency.]

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

AMEND: 410-148-0020

RULE SUMMARY: Remove reference to a funding line on the Prioritized List. Update reference to the OHA Prioritized List. Replace references to a "client" with "Member." Capitalize defined terms.

CHANGES TO RULE:

410-148-0020

Home Enteral/Parenteral Nutrition and IV Services ¶

(1) The Division shall make payment for ~~m~~Medically ~~a~~Appropriate and ~~m~~Medically ~~n~~Necessary goods, supplies, and services for home enteral/parenteral nutrition and IV therapy on written order or prescription. ¶

(a) The order or prescription must be dated and signed by a licensed prescribing ~~p~~Practitioner. The order shall be legible and specify the service required, the ICD-10-CM ~~d~~Diagnosis ~~e~~Code(s), the route of administration, the amounts prescribed, and the length of time needed. ¶

(b) The prescription or written ~~p~~Practitioner's order must be retained on file by the ~~p~~Provider of service for the period of time specified in the ~~Division's General Rules, OAR chapter 410, division 120.~~ ¶

(c) A nutritional assessment performed by a registered dietitian or the treating ~~p~~Practitioner and a new prescription are required once a year for ongoing services. ¶

(d) Also covered are services for subcutaneous, epidural and intrathecal injections requiring pump or gravity delivery. ¶

(2) All claims for enteral/parenteral nutrition and IV services require a valid ICD-10-CM ~~d~~Diagnosis ~~e~~Code. It is the ~~p~~Provider's responsibility to obtain the actual ~~d~~Diagnosis ~~e~~Code(s) from the prescribing ~~p~~Practitioner. Reimbursement shall be made according to ~~e~~Covered ~~s~~Services on ~~funded lines of the Health Services Commission's~~ the OHA Prioritized List of Health Services, and these rules. ¶

(3) The Division shall cover one initial nursing service visit to assess the home environment and appropriateness of enteral/parenteral nutrition or IV services in the home setting when recommended by the treating ~~p~~Practitioner to establish the ~~client~~Member's treatment plan. ~~/This nursing service visit for assessment purposes does not require~~ ~~p~~Prior ~~a~~Authorization. ¶

(4) Nursing service visits, except the assessment nursing visit, specific to this Home Enteral/Parenteral and IV services program are provided in the home or an Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS) and shall be reimbursed by the Division only when ~~p~~Prior ~~a~~Authorized, and performed by a person who is licensed by the Oregon State Board of Nursing to practice as a Registered Nurse. All registered nurse delegated or assigned nursing care tasks must comply with the Oregon State Board of Nursing, Nurse Practitioner Act and Administrative Rules regulating the practice of nursing. ¶

(5) Payment for services identified in the Home Enteral/Parenteral Nutrition and IV Services ~~p~~Provider rules shall be made only when provided in the ~~client~~Member's place of residence.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-148-0260

Home Enteral Nutrition ¶

(1) Indications and limitations of coverage and medical appropriateness: The Division may cover home enteral formula, oral nutritional supplements, equipment, supplies, and services for clients of any age. Refer to Table 148-0260-1 and the following guidelines: ¶

(a) Enteral nutrition refers to nutritional formula administered by tube or orally fed into the gastrointestinal tract (HCPCS codes may include, but are not limited to, B4149 through B4162). Depending on the route of administration, additional equipment and supplies may be covered; ¶

(b) Blenderized enteral formula, whether administered by tube or orally fed, describes formulas containing natural foods that are blenderized and packaged by a manufacturer. Code B4149 must not be used for foods that have been blenderized by the beneficiary or caregiver; ¶

(c) Refer to the product classification list on the Medicare Pricing, Data Analysis and Coding (PDAC) contractor website for appropriate Healthcare Common Procedure Coding System (HCPCS) codes assigned to formula, supplements, equipment, and supplies; ¶

(d) If the formula, item, or supply is not listed on the PDAC contractor website, the provider must contact the PDAC contractor for a coding determination. The Medicare Pricing, Data Analysis and Coding contractor is responsible for assisting DMEPOS providers and manufacturers in determining which HCPCS code shall be used to describe DMEPOS items; ¶

(2) Enteral formula and nutritional supplements administered orally; ¶

(a) Prior authorization is required. ¶

(b) Enteral formula and oral nutritional supplements documented as the primary source of nutrition, for a client of any age, meets criteria for expedited prior authorization review; ¶

(c) Oral nutritional formula and supplements may be approved when the following criteria has been met: ¶

(A) For Adults: ¶

(i) An assessment performed by a registered dietitian or treating practitioner, at onset and annually thereafter, documenting the client is unable to meet their recommended caloric/protein or micronutrient needs through regular, liquified, blenderized, or pureed foods in any modified texture or form; and ¶

(ii) Documentation showing the prescribed oral nutritional formula and/or nutritional supplements are an integral part of treatment for a nutritional deficiency as identified by one of the following conditions: ¶

(I) Diagnosed acute or chronic malnutrition; or ¶

(II) Documentation of weight, either currently or historically, supported by oral nutritional supplements; or ¶

(III) Increased metabolic need resulting from severe trauma; or ¶

(IV) Malabsorption difficulties (e.g., short-gut syndrome, fistula, cystic fibrosis, renal dialysis); or ¶

(V) Inborn errors of metabolism (e.g., fructose intolerance, galactosemia, maple syrup urine disease (MSUD), or phenylketonuria (PKU); or ¶

(VI) Ongoing cancer treatment, advanced Acquired Immune Deficiency Syndrome (AIDS) or pulmonary insufficiency; or ¶

(VII) Oral aversion or other psychological condition making it difficult for a client to consume their recommended caloric/protein or micronutrient needs through regular, liquified, blenderized, or pureed foods in any modified texture or form; ¶

(B) For EPSDT Beneficiaries as defined in Chapter 410 Division 151: ¶

(i) An assessment performed by a registered dietitian or treating practitioner, at onset and annually thereafter, documenting the prescribed nutritional formula and/or nutritional supplementation is medically necessary and appropriate as an integral part of treatment for any condition noted above (I-VII) or for the prevention of nutritional deficiency or malnutrition as identified by one of the following: ¶

(I) Documentation showing the client is unable to meet their recommended caloric/protein or micronutrient needs through regular, liquified, blenderized, or pureed foods in any modified texture or form; or ¶

(II) Malabsorption or other diagnosed medical condition which involves dietary restriction as part of the treatment, including but not limited to food allergy, Eosinophilic disorders (EoE), Food Protein Induced Enterocolitis (FPIES); or ¶

(III) Documented delayed growth or failure to thrive; ¶

(ii) For EPSDT beneficiaries, the terms medically necessary and medically appropriate are defined in OAR Chapter

410 Division 151;¶

(3) Enteral formula administered by tube for a client of any age;¶

(a) Enteral nutrition is covered for a client of any age who requires feedings via an enteral access device (tube) to provide sufficient nutrients to maintain weight and strength otherwise not possible by dietary adjustment and/or oral supplements;¶

(b) Supplies;¶

(A) The unit of service for the supply allowance (B4034, B4035, B4036, or B4148) is one (1) per day;¶

(i) Enteral feeding supply kit allowances (B4034, B4035, B4036, and B4148) are all-inclusive with the exception of B4105 in-line digestive enzyme cartridge. ¶

(ii) Two in-line digestive enzyme cartridges (B4105) per day is considered reasonable and necessary for clients diagnosed with Exocrine Pancreatic Insufficiency (EPI);¶

(iii) The feeding supply allowance (B4034, B4035, B4036, and B4148) must correspond with the method of administration (syringe, pump, gravity, elastomeric control fed);¶

(I) The daily supply allowances include, but are not limited to, a catheter/tube anchoring device, feeding bag/container, flushing solution bag/container, administration set tubing, extension tubing, feeding/flushing syringes, gastrostomy tube holder, dressings (any type) used for gastrostomy tube site, tape (to secure tube or dressings), Y connector, adapter, gastric pressure relief valve, declogging device;¶

(II) Prior authorization is required for specialty supply items (e.g., Farrell Valve) and there must be documentation to support the need;¶

(B) Three nasogastric tubes (B4081, B4082, and B4083), or one gastrostomy/jejunostomy tube (B4087 or B4088) every three (3) months is considered reasonable and necessary. One back-up gastrostomy/jejunostomy tube (B4087 or B4088) may be covered when prescribed for an EPSDT beneficiary as defined in Chapter 410 Division 151.-/For those clients requiring more frequent changes or replacement of a non-functional tube, prior authorization is required and there must be documentation to support the need;¶

(4) Initial delivery of each enteral formula, oral supplement, equipment, and supplies;¶

(a) For each new formula or supplement prescribed, suppliers shall provide a sixty (60) day supply regardless of which delivery method is utilized.¶

(b) The prescribed length of need must exceed sixty (60) days for this rule to apply;¶

(5) Refill requirements for formula items and supplies provided on a recurring basis;¶

(a) For all formulas, nutritional supplements, and supplies that are provided on a recurring basis as refills to the original order, suppliers are required to have contact with the client or designee either by call, text, or email prior to dispensing to confirm any changes or modifications to the order;¶

(b) Contact with the client or designee regarding refills shall take place no less than 35 calendar days prior to the end of usage for the current product and the next scheduled delivery/shipping date;¶

(c) For delivery or shipment of refills, the supplier shall dispense the formula and supplies no less than thirty (30) calendar days prior to the end of usage for the current product regardless of which delivery method is utilized;¶

(A) Regardless of utilization, a supplier must not dispense more than a 1-month quantity of formula or supplies on a recurring basis;¶

(B) Automatic shipments on a pre-determined basis, even if authorized by the client or designee, are not allowed;¶

(C) Suppliers may dispense more than a 1-month quantity of formula or supplies only on a periodic basis to ensure continuation of care during times of travel or when the client is away from the home for an extended period of days. Documentation of the reason for the additional quantity and client's travel or time away from home, shall be kept on file with the supplier and made available to the Division upon request. ¶

(6) For enteral nutrition equipment, all repair and maintenance are subject to rule OAR 410-148-0080;¶

(7) Food thickener (B4100) administered orally;¶

(a) A thickener is an additive that decreases the flow rate of thin liquids. A thickener, when medically necessary and medically appropriate, shall be covered when prescribed for a client of any age who has participated in a swallowing evaluation or study and for the treatment of a swallowing disorder resulting from one of the following: ¶

(A) A diagnosis of dysphagia which negatively impacts the ability to swallow; or¶

(B) Chronic diseases such as, but not limited to, Parkinson's, dementia, reflux disease, stroke, neuromuscular disease/disorder, and spinal cord injury; or¶

(C) Treatment of head, neck, or throat cancer; or¶

(D) Documented aspiration of food or liquid associated with chronic illness or disease. ¶

(b) Annual follow up with treating practitioner is required to ensure the food thickener remains medically necessary and to confirm any changes or modifications to the order.¶

(8)-/Oral nutritional formula and supplements may be covered through the point-of-sale pharmacy system.-/Refer to the Pharmaceutical Services administrative rules, Chapter 410 Division 121, for coverage and prior authorization requirements;¶

(9) Human donor milk;¶

(a) Refer to the OHA Prioritized List Guideline Note for coverage guidelines;¶

(b) Prior authorization is required;¶

(10) Procedure codes;¶

(a) Refer to Table 148-0260-1;¶

(b) Codes that have "PA" indicated require prior authorization;¶

(11) Billing instructions: ¶

(a) The allowance for all items includes delivery regardless of which delivery method is utilized;¶

(b) Oral formula and/or nutritional supplements can be billed through the on-line point of sale pharmacy system, or by paper using the CMS 1500 claim form or the electronic 837P claim form. Providers are required to use the product's National Drug Code (NDC) and Healthcare Common Procedure Coding System (HCPCS) code when billing the CMS 1500 or electronic 837P claim form;¶

(12) Documentation requirements: ¶

(a) The purchase, rental, or repair of durable medical equipment and the purchase of supplies must have an order from the prescribing practitioner prior to dispensing items to a client;¶

(b) A new prescription is required when: ¶

(A) There is a change in the item(s), frequency of use, amount prescribed, a change in the length of need, or a previously established length of need expires. ¶

(B) A new prescription is required annually;¶

(c) For services requiring prior authorization (PA), submit documentation that supports coverage criteria in this rule are met;¶

(d) All nutritional formula, equipment, supplies, and services shall be documented as medically appropriate and medically necessary by the registered dietitian and/or treating practitioner;¶

(A) "Medically Appropriate" has the meaning given that term in OAR Chapter 410 Division 120 for adult beneficiaries, and as defined in Chapter 410 Division 151 for EPSDT beneficiaries;¶

(B) "Medically Necessary" has the meaning given that term in OAR Chapter 410 Division 120 for adult beneficiaries, and as defined in Chapter 410 Division 151 for EPSDT beneficiaries;¶

(e) Documentation that coverage criteria have been met must be present in the client's medical records. These records shall be kept on file with the DME provider and made available to the Division on request.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-148-0260.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:
<https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=340094>

RULE SUMMARY: Remove reference to nonfunded region of the Prioritized List. Update reference to the OHA Prioritized List. Update reference to OAR 410-141-3830.

CHANGES TO RULE:

410-151-0001

Definitions-

The definitions in this rule apply to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program only.¶¶

(1) "EPSDT Dentally Appropriate"¶¶

(a) Means dental services, items, or dental supplies that are:¶¶

(A) Recommended by a licensed health practitioner practicing within the scope of their license; and¶¶

(B) Safe, effective, and appropriate for an EPSDT Beneficiary based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence, which includes medical literature and expert consensus opinion and takes into account EPSDT Beneficiary values; and¶¶

(C) Impactful in improving access to care, ability to actively participate in care, work, school, or social activities; and not solely for the convenience or preference of an EPSDT Beneficiary, caregiver, or a provider of the service, item, or dental supply; and¶¶

(D) The most cost-effective level or type of health services, items, or supplies that are covered services that can be safely and effectively provided to an EPSDT Beneficiary.¶¶

(b) All covered services must be EPSDT Dentally Appropriate for the EPSDT Beneficiary but not all EPSDT Dentally Appropriate services are covered services.¶¶

(2) "EPSDT Beneficiary" means an individual under the age of 21 who is covered by the Oregon Health Plan (OHP) or an individual in the Young Adults with Special Health Care Needs (YSHCN) program as defined in OAR 410-200-0455¶¶

(3) "EPSDT Medically Appropriate:"¶¶

(a) Means health services, items, or medical supplies that are:¶¶

(A) Recommended by a licensed health practitioner practicing within the scope of their license; and¶¶

(B) Safe, effective, and appropriate for the EPSDT Beneficiary and generally recognized by the relevant scientific or professional community based on the best available evidence, which includes medical literature and expert consensus opinion and takes into account EPSDT Beneficiary values; and¶¶

(C) Impactful in improving access to care, ability to actively participate in care, work, school, or social activities and not solely for the convenience or preference of an EPSDT Beneficiary, caregiver, or a provider of the service, item, or medical supply; and¶¶

(D) The most cost-effective level or type of health services, items, or medical supplies that are covered services that can be safely and effectively provided to an EPSDT Beneficiary.¶¶

(b) All covered services must be EPSDT Medically Appropriate for the EPSDT Beneficiary, but not all EPSDT Medically Appropriate services are covered services.¶¶

(4) "EPSDT Medically Necessary:"¶¶

(a) Means health services, items and medical supplies that are required to address one or more of the following for an EPSDT Beneficiary:¶¶

(A) The prevention, diagnosis, treatment or amelioration of an EPSDT Beneficiary's disease, condition, or disorder that results in health impairments or a disability;¶¶

(B) The ability for an EPSDT Beneficiary to achieve age-appropriate growth and development. Services that may be EPSDT Medically Necessary to achieve age-appropriate growth and development include but may not be limited to services that are reasonably calculated to improve the EPSDT Beneficiary's ability to participate in work or school, or the prevention, diagnosis, detection, treatment, cure, correction, reduction, or alleviation of the effects of a physical, mental, behavioral, nutritional, dental, genetic, developmental or congenital condition, injury, or disability, regardless of whether they are consistent with the condition and treatment pairs identified ~~in~~ on the OHA Prioritized List of Health Services ~~(defined in OAR 410-120-0000) or are below the funding line on the Prioritized List of Health Services; per OAR 410-141-3830;~~ ¶¶

(C) The ability for an EPSDT Beneficiary to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or¶¶

(D) The opportunity for an EPSDT Beneficiary receiving Long Term Services & Supports (LTSS) to have access to the benefits of non-institutionalized community living, to achieve person-centered care goals, to participate in their own care planning, and to live and work in the setting of their choice.¶¶

(b) An EPSDT Medically Necessary service must also be EPSDT Medically Appropriate. All covered services must be EPSDT Medically Necessary for the EPSDT Beneficiary.

Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065, 414.150

RULE SUMMARY: Remove reference to nonfunded region of the Prioritized List. Update reference to the OHA Prioritized List. Update reference to OAR 410-141-3830. Replace references to an “managed care entity” or “MCE” with a “coordinated care organization” or “CCO.”

CHANGES TO RULE:

410-151-0002

Coverage Requirements

(1) The coverage requirements for services to EPSDT Beneficiaries set forth in this Rule supersede any other coverage standards or requirements set forth in any other Medical Assistance rules that are applicable to non-EPSDT Beneficiaries, regardless of whether the other standards or requirements conflict or are otherwise inconsistent with the EPSDT coverage requirements in this Rule. ¶

(2) The Oregon Health Authority (the Authority) and Managed Care Entities (~~MCECCOs~~) must cover services that are EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) for EPSDT Beneficiaries, even if: ¶

~~(a) If the services are not included or paired on the OHA Prioritized List of Health Services (defined in OAR 410-120-0000); or ¶~~

~~(b) The service is below the funding line on the Prioritized List of Health Services. 41-3830. ¶~~

(3) The Authority and ~~MCECCOs~~ may not deny coverage of services for EPSDT Beneficiaries without a case-by-case review for EPSDT Medical Necessity and EPSDT Medical Appropriateness (or EPSDT Dental Appropriateness). It is allowable for services to be denied for EPSDT Beneficiaries after a case-by-case review in which it is determined by the Authority or the ~~MCECCO~~ that the service is not EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) for that specific EPSDT Beneficiary. Specific circumstances in which the Authority and ~~MCECCOs~~ may deny coverage of services for an EPSDT Beneficiary are outlined in a guidance document, effective January 1, 2023, available at <https://www.oregon.gov/oha/hsd/ohp/pages/epsdt.aspx>. ¶

(4) The Authority and ~~MCECCOs~~ must cover Durable Medical Equipment for EPSDT Beneficiaries in accordance with sections (1) through (3) of this rule and OAR 410-122-0010 through OAR 410-122-0720. ¶

(5) Providers must not refuse to render or refer for EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) care. Coverage decisions must be made by the Authority or the ~~MCECCO~~ in accordance with the requirements in sections (1) through (4) of this rule and any denial of coverage must be provided in writing by the Authority or the ~~MCECCO~~ in accordance with the requirements in OAR 410-151-0007. Statutory/Other Authority: ORS 413.042

Statutes/Other Implemented: ORS 414.025, 414.065, 414.150

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-170-0080

Services ¶¶

(1) The BRS contractor shall, and require that its BRS provider, provide services to the BRS client in accordance with the BRS client's service plan.-¶¶

(2) BRS contractor staff shall, and require that its BRS provider, staff structure and directly supervise all services.-¶¶

(3) Types of Services:-¶¶

(a) Milieu Therapy:-¶¶

(A) The BRS contractor shall, and require that its BRS provider, provide the BRS client structured activities and planned interventions designed to normalize psycho-social development, promote safety, stabilize environment, and assist in responding in developmentally appropriate ways;-¶¶

(B) The program's staff shall monitor the BRS client in these activities, which include developmental, recreational, academic, rehabilitative, or other productive work;-¶¶

(C) Milieu therapy occurs in concert with one of the other types of services. Because milieu therapy must occur in concert with another BRS service, the BRS contractor may not and shall ensure that its BRS provider does not count milieu therapy in the number of hours of BRS services provided to the BRS client per week.-¶¶

(b) For crisis counseling, the BRS contractor shall, and require that its BRS provider, provide the BRS client counseling on a 24-hour basis to stabilize the client's behavior until the problem can be resolved or assessed and treated by a qualified mental health professional or licensed medical practitioner;-¶¶

(c) For individual and group counseling, the BRS contractor shall, and require that its BRS provider, provide face-to-face individual or group counseling sessions to the BRS client that are designed to remediate the problem behaviors identified in the client's service plan;-¶¶

(d) For parent training, the BRS contractor shall, and require that its BRS provider, provide planned activities or interventions (face-to-face or by telephone) to the BRS client's family or identified aftercare resource family. Parent training is designed to assist the family in identifying the specific needs of the BRS client, support the client's efforts to change, and improve and strengthen parenting knowledge or skills indicated in the service plan as being necessary for the client to return home or to another community living resource;-¶¶

(e) For skills-training, the BRS contractor shall, and require that its BRS provider, provide the BRS client planned individual or group sessions using evidence-based or evidence-informed approaches or models designed to improve specific areas of functioning in the client's daily living as identified in the service plan. Skills-training may be designed to develop appropriate social and emotional behaviors, improve peer and family relationships, improve self-care, encourage conflict resolution, reduce aggression, improve anger control, and reduce or eliminate impulse and conduct disorders.-¶¶

(f) For Face-to-face services described in sections (3)(c-d) of this rule the BRS contractor shall, and require it's BRS provider to, provide them in accordance with the definition standards described in OAR 410-170-0020(30). Any barriers BRS contractors or their BRS providers encounter when attempting to meet these standards including, but not limited to, temporary technical issues, health and safety precautions, or client preference should be documented in service notes and attempts should be made to mitigate barriers as they arise.-¶¶

(4) Telehealth for Behavior Rehabilitation Services:¶¶

(a) To utilize telehealth for services required by the BRS program, the BRS contractor and BRS providers shall:-¶¶

(A) Comply with Telehealth for Behavioral Health requirements described in OAR 410-172-0850;-¶¶

(B) Comply with ~~the OHA Prioritized List of Health s~~Services guidelines for telephone and e-mail consultation described in OAR 410-141-3830; and¶¶

(C) Comply with agency specific BRS Telehealth program rules and policies.¶¶

(b) The BRS contractor and BRS providers shall develop written telehealth policy that complies with section (4)(a)(A-C) of this rule. At minimum, the policy shall describe:-¶¶

(A) The circumstances the provider may provide BRS services via telehealth;-¶¶

(B) The telecommunication technologies the BRS contractor or BRS provider has implemented to deliver services via telehealth; and¶¶

(C) The process to obtain an individual's informed consent in accordance with ORS 107.154, 179.505, 179.507, 192.515, including a sample form.¶¶

(c) The BRS contractor and BRS providers may utilize telehealth for services that require a face-to-face setting when there is a documented barrier to providing in-person services, as follows:¶¶

- (A) Services via telehealth shall be provided by a qualified program staff within their scope of position;¶
 - (B) Service notes for phone, individual or group counseling shall follow the same criteria as face-to-face counseling and identify the session was conducted by telehealth and the reason for the use of telehealth; and¶
 - (C) Individual or group counseling via telehealth shall meet HIPAA and 42 CFR Part 2 standards for privacy; and¶
 - (D) Any barriers to meeting the standards set in the face-to-face definition found in OAR 410-170-0020(30), including but not limited to temporary technical issues, health and safety precautions, or client preference should be documented in service notes and attempts should be made to mitigate barriers as they arise.-¶
 - (5) The BRS contractor shall, and require that its BRS provider:-¶
 - (a) Provide a combination of services necessary to comply with the BRS client's service plan and the requirements in OAR 410-170-0090 for the appropriate BRS type of care;-¶
 - (b) Create and maintain written documentation describing the services provided to each BRS client that includes at a minimum the following information:-¶
 - (A) Name of the BRS client;-¶
 - (B) Date of service;-¶
 - (C) Name and position of the staff member providing the service to the BRS client;-¶
 - (D) Length of time staff spent providing the service to the BRS client;-¶
 - (E) Description of the service provided; and-¶
 - (F) Description of the BRS client's participation in the service.-¶
 - (c) Create and maintain a written weekly record in each BRS client's case file with the total number of service hours provided each day to the client and a breakdown of the number of hours spent providing each type of service described in section (3) of this rule; and-¶
 - (d) Ensure that social service staff review the documentation described in this section each week for quality, content, and appropriateness with the BRS client's service plan.
- Statutory/Other Authority: ORS 413.042, ORS 414.065, ORS 743A.058
- Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: Update reference to the OHA Prioritized List.

CHANGES TO RULE:

410-172-0770

Individual Eligibility for Applied Behavioral Analysis Treatment ¶

(1) Prior to receiving services, individuals receiving ABA services for the treatment of autism spectrum disorder (ASD) shall have an evaluation by a licensed practitioner, described in OAR 410-172-0760(1)(a-d), experienced in the diagnosis and treatment of autism using the current DSM criteria that includes: ¶

(a) A diagnosis of an ASD listed on the ASD line of the ~~Health Evidence Review Commission's (HERC)~~OHA Prioritized List; ¶

(b) Documentation of and results from a standardized, validated tool, such as the Autism Diagnostic Observation Schedule (ADOS), that has been used to substantiate the autism disorder; ¶

(c) Documentation of individual core features of autism as identified through a review of ASD diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM 5); ¶

(d) Documentation that a parent or caregiver has been interviewed; ¶

(e) Documentation that there was a review of relevant medical records; ¶

(f) Documentation that the practitioner was able to observe the individual directly; ¶

(g) Documentation of developmental status using validated assessments or a combination of such assessments, such as the Vineland. This information may be provided by a licensed ABA provider; ¶

(h) Documentation of a comprehensive medical exam. A physical exam from the most recent well child care visit may be submitted if within one year for children aged 1-6, or within two years for children 6-18. The physical exam must be completed before starting ABA but may not be allowed to delay or interrupt ABA services; ¶

(i) Documentation that an audiology or hearing test has been performed within one year for children aged 2 through 5, or within two years for children aged 6 through 18. The audiology or hearing test must be completed before starting ABA but may not be allowed to delay or interrupt ABA services; ¶

(A) Newborn assessment is not sufficient after the age of 24 months; ¶

(B) Hearing tests from primary care offices and schools are sufficient if there are no concerns regarding hearing; ¶

(j) Any other documentation, if available, that would substantiate the diagnosis of autism or stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder including but not limited to the following: ¶

(A) Notes from well-child visits or other medical professionals; ¶

(B) Results from any additional assessments including but not limited to IQ, achievement tests, speech and language tests, and assessments of adaptive functioning. ¶

(k) A referral for ABA treatment with or without specification of hours or intensity that shall include: ¶

(A) A diagnosis of ASD or stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder; ¶

(B) A copy of the evaluation described in 410-172-0770(1); ¶

(C) A referral for ABA treatment with or without specification of hours or intensity. ¶

(2) Prior to receiving services, individuals receiving ABA for the treatment of stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder shall have an evaluation by a licensed practitioner, practicing within their scope of practice, who has training or experience in the diagnosis and treatment of stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder that includes results from a questionnaire or observations that have been used to substantiate the diagnosis. ¶

(3) Prior authorization for intensive and less intensive interventions must be based on an individualized determination of medical appropriateness for each individual and relevant guideline notes from the ~~HERC~~OHA Prioritized List at the initiation and continuation of ABA services. Services in excess of the ~~HERC~~OHA Prioritized List coverage guidance or guideline notes shall be provided when medically appropriate for a particular individual, including individuals age 13 and older. Relevant factors to consider when making a prior authorization determination include but are not limited to the following: ¶

(a) Severity; ¶

(b) Depth and breadth of previous treatment; ¶

(c) How recently the diagnosis has been made. For example, if the diagnosis has been made after the child turned 13, intensive treatment shall be considered; ¶

(d) Comorbidities such as psychiatric disorders, developmental delays, and intellectual disability may make it harder to treat ASD and may require more intensity of treatment to be effective; ¶

(e) Factors that would be contrary to the efficacy of ABA or increased intensity of ABA services.

Statutory/Other Authority: ORS 413.042, 430.640

Statutes/Other Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

AMEND: 410-172-0850

RULE SUMMARY: Update reference to the OHA Prioritized List. Update URL for the Prioritized List.

CHANGES TO RULE:

410-172-0850

Telemedicine for Behavioral Health ¶

(1) Telemedicine encompasses different types of programs, services, and delivery mechanisms for medically appropriate covered services within the recipient's benefit package.¶

(a) Patient consultations using telephone and online or electronic mail (e-mail) are covered when billed services comply with the practice guidelines set forth ~~by the Health Evidence Review Commission and the applicable HERC-approved code requirements, delivered consistent with the HERC Evidence Based Guidelines;~~ in the OHA Prioritized List; ¶

(b) Patient consultations using videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a provider located in a distant site and the recipient being evaluated and located in an originating site, is covered when billed services comply with the billing requirements stated below.¶

(2) Behavioral health services specifically identified as allowable for telephonic delivery are listed on the Behavioral Health Fee schedule published by the Authority.¶

(3) Unless expressly authorized in OAR 410-120-1200 (Exclusions), other types of telecommunications are not covered such as images transmitted via facsimile machines and electronic mail when:¶

(a) Those methods are not being used in lieu of videoconferencing, due to limited videoconferencing equipment access; or,¶

(b) Those methods and specific services are not specifically allowed pursuant to the ~~Oregon Health Evidence Review Commission's~~ OHA Prioritized List of Health Services and Evidence Based Guidelines.¶

(4) Providers billing for covered telemedicine services shall:¶

(a) Comply with HIPAA and the Authority's Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records;¶

(b) Obtain and maintain technology used in the telemedicine communication that is compliant with privacy and security standards in HIPAA and the Authority's Privacy and Confidentiality Rules set forth in OAR 943 division 14;¶

(c) Ensure policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records (whether oral or recorded in any form or medium) to unauthorized individuals;¶

(d) Comply with the relevant ~~HERC evidence-based guideline notes~~ for telephone and e-mail consultation. ~~Refer to the current prioritized list and evidence-based guidelines at <http://www.oregon.gov/OHA/HPA/CSI-HERC/Pages/included-in-the-current-OHA-Prioritized-List.aspx>; at [web TBD];~~ ¶

(e) Maintain clinical and financial documentation related to telemedicine services as required in OAR 410-120-1360.¶

(5) For purposes of behavioral health services, the Authority shall provide coverage for telemedicine services to the same extent that the services would be covered if they were provided in person.

Statutory/Other Authority: ORS 413.042, 430.640

Statutes/Other Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715